



2010 Performance Measure Comparative Analysis Report

Washington State Healthy Options Program
Children's Health Insurance Program
Washington Medicaid Integration Partnership

November 2010

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Presented by

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Presented to Washington State Department of Social & Health Services,
Medicaid Purchasing Administration

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Executive Summary

The Medicaid program in Washington, administered by the Medicaid Purchasing Administration (MPA), provides healthcare benefits for more than 1 million low-income residents, more than half of whom are enrolled in Healthy Options, the state's managed care program. In addition, about 3,800 beneficiaries are enrolled in the Washington Medicaid Integration Partnership (WMIP), which serves categorically needy aged, blind, and disabled clients in Snohomish County.

This report presents the 2010 findings for Healthy Options plans in numerous Healthcare Effectiveness Data and Information Set (HEDIS[®]) performance measures.* Developed and maintained by the National Committee for Quality Assurance (NCQA), the HEDIS measures are used by consumers to compare health plan performance; by purchasers to compare plan data with national averages; and by health plans to identify best practices or improvement opportunities. MPA has used HEDIS measures to assess health plan performance since 1998.

Acumentra Health produced this report under its contract with MPA as the External Quality Review Organization for Washington. This assessment covers health care delivered in reporting year 2010 by seven managed care organizations (MCOs):

- Asuris Northwest Health
- Columbia United Providers
- Community Health Plan
- Group Health Cooperative
- Kaiser Permanente Northwest
- Molina Healthcare of Washington
- Regence BlueShield

HEDIS results for a measurement year (the year in which care is given) are gathered, audited, and reported the following year and are based on a statistically valid random sample of health plan enrollees.

Results

As a group, the Healthy Options plans are providing care to enrollees at rates that are nearly identical to, or better than, the NCQA national Medicaid averages for

- seven indicators of childhood immunization status (DTaP, IPV, HiB, Hep B, PCV, Combo 2, and Combo 3)
- four of eight indicators of diabetes care for which comparison can be made (HbA1c tests, dilated retinal exams, and two blood-pressure control indicators)

In addition, the reported service utilization rates for Healthy Options enrollees remain below the national averages—generally considered positive—in all categories of inpatient and ambulatory care except for maternity care. In particular, Healthy Options enrollees visit emergency rooms at significantly lower rates compared with Medicaid enrollees nationwide.

*HEDIS is a registered trademark of the National Committee for Quality Assurance.

In contrast, the Healthy Options plans as a group continue to lag behind the national average in providing well-child care (WCC) visits for infants, children, and adolescents, as well as in lipid screening and control and in monitoring for diabetic nephropathy.

This report presents fifth-year performance measurement data for the WMIP. In 2010, HbA1c testing for WMIP enrollees rose to its highest rate in four years. However, other measures of diabetes care—including blood pressure control and delivery of eye exams, lipid screening, and nephropathy monitoring—showed declines from the previous year. The results for utilization measures were mixed. Total inpatient acute and nonacute care discharges and days declined from 2009, as did the average length of stay in nonacute care, though the declines were not statistically significant. At the same time, the rate of visits for outpatient care rose significantly. In addition, a significantly smaller percentage of WMIP enrollees received outpatient follow-up care within 30 days after discharge from hospitalization for mental illness.

The WMIP program contractor, Molina Healthcare of Washington, also calculated four non-HEDIS measures for the WMIP: chronic dementia, falls, depression, and transition of care. The results of those four measures are not analyzed in this report.

Beginning this year, data on the frequency of selected procedures and on utilization measures for the Healthy Options plans are not presented in the main body of this report. Complete data tables for all indicators appear in Appendix B.

Focus on member-level data

MPA required the Healthy Options plans to submit de-identified member-level data (including elements for gender, primary language, race/ethnicity, and county) on childhood immunizations for 2009 and 2010, and on WCC visits for 2010. Analysis of the member-level data revealed the following significant findings with respect to geographical region and by the enrollees' primary language, race/ethnicity, and urban or rural residence.

Immunizations: Depending on the vaccine, immunization rates were highest in south central Washington (Region 2), the Tacoma area (Region 5), or King County (Region 4); the lowest rates for almost all antigens and combinations occurred in western and southwestern counties (Region 6). For the majority of antigens and combinations, immunizations were highest among Spanish-speaking enrollees and lowest among Russian speakers. Asian enrollees tended to have higher immunization rates than other racial groups, while Hispanic enrollees were immunized at higher rates compared with non-Hispanic enrollees. Urban dwelling enrollees were immunized at significantly higher rates than rural dwellers for most indicators.

WCC visits: The highest WCC visit rates occurred in King County (Region 4) for children and adolescents, and in Region 3, north of Seattle, for infants. The lowest visit rates occurred east of the Cascades (Regions 1 and 2). With respect to primary language, visit rates for children and adolescents were highest for Spanish speakers and lowest for Russian speakers. For the same age groups, Hispanic enrollees received visits at higher rates than non-Hispanic enrollees. Among adolescents, African-American enrollees had significantly higher WCC visit rates than other groups. Results by urban/rural residence were mixed, depending on age group.

Recommendations

Previous reports in this series have outlined recommendations for MPA and the Healthy Options plans, aimed at improving access to care and the quality and timeliness of care. Many of those recommendations remain valid, although their current feasibility may be limited by the significant resource constraints facing the Washington Medicaid program.

To sustain long-term improvement in performance measures, Acentra Health recommends that MPA

- continue to foster public health initiatives and partnerships such as the Washington State Collaborative to Improve Care, and the CHILD Profile immunization registry
- collaborate with health plans to provide performance feedback to clinics and providers
- help health plans study and overcome the barriers to collecting administrative data for HEDIS measures so that the plans can report measures more easily and can direct more resources toward improving care for enrollees
- work with health plans to implement the provisions of the Child Health-Care Act (SB 5093), the goal of which is to ensure that all children in Washington have access to appropriate healthcare services by linking children to medical homes
- consider organizing a collaborative performance improvement project (PIP) among the MCOs to reduce nonurgent emergency room (ER) utilization, encourage MCOs to provide routine ER utilization reports to providers, and promote enrollee education to help reduce preventable ER visits

Acentra Health recommends that WMIP

- conduct member-level analysis to “drill down” on performance measures and target specific areas of improvement

Introduction

The Medicaid program in Washington, administered by MPA, provides healthcare benefits for more than 1 million low-income residents, more than half of whom are enrolled in Healthy Options, the state's managed care program. Healthy Options enrollees include

- children enrolled in the Children's Health Insurance Program (CHIP)
- other categorically eligible children and mothers
- Medicaid-eligible pregnant women
- children of adults who are enrolled in the Basic Health Plus program

This report presents Healthy Options plan results for measurement year 2009 (reporting year 2010) on the HEDIS measures that MPA requires the plans to report. These widely accepted measures allow comparison of the Washington plans' performance with national averages for the Medicaid population.

As part of the contract for delivering services to Medicaid enrollees, MPA requires Healthy Options plans to use HEDIS to assess their performance on measures of care effectiveness, access, and use of services; to examine utilization patterns for specific services; and to report information on enrollees' race and ethnicity.

Acumentra Health has reported on the Healthy Options plans' HEDIS measures each year since 2005. Overall, the yearly reports have showed gradual improvement in many measures of care provided to enrollees, although variations in health plan performance point to opportunities for further improvement, peer learning, and partnership among plans.

Table 1 shows the name and acronym of each plan, the number of enrollees, and the percentage of the Healthy Options population served by each plan. The report also presents the results of quality measurements for the WMIP, a pilot project aimed at improving health care for aged, blind, and disabled residents who are eligible for both Medicaid and Medicare coverage and who have complex healthcare needs.

Table 1. Healthy Options health plans and enrollees as of October 2010.^a

Health plan	Acronym	Number of enrollees	Percentage of all enrollees
Asuris Northwest Health	ANH	2,880	0.4
Community Health Plan	CHP	215,372	32.7
Columbia United Providers	CUP	43,177	6.6
Group Health Cooperative	GHC	23,089	3.5
Kaiser Permanente Northwest	KPNW	621	0.1
Molina Healthcare of Washington	MHW	333,593	50.7
Regence BlueShield	RBS	38,945	5.9

^a Source: Department of Social & Health Services. Enrollment includes Healthy Options, CHIP, and Basic Health Plus.

Map of Washington State showing managed care enrollment by county. The map is color-coded: light blue for voluntary enrollment with no capacity, pink for voluntary enrollment with one plan, and white for voluntary enrollment with multiple plans. Callouts highlight specific regions: "CHP RBS" in the northwest, "CHP MHW RBS" in the north-central area, "CHP GHG MHW" in the west-central area, and "CHP" in the south-central area.

This report presents the health plans' results for each HEDIS indicator. Findings are displayed in bar charts that show

- individual health plan scores for reporting years 2009 and 2010
- the aggregated Healthy Options statewide averages for 2009 and 2010
- the NCQA national Medicaid averages for 2009 and 2010

Asterisks next to the 2010 percentages show statistically significant changes in plan performance from 2009 to 2010. Each graph also shows the 95 percent confidence interval (CI), which indicates the upper and lower limits within which each plan percentage would be expected to fall 95 times if 100 identical studies were conducted. A small CI indicates a higher likelihood that the sample plan percentage shown by the bar is a reliable estimate of the percentage that applies to plan members overall; a large CI indicates a lower likelihood that the percentage found in the plan sample reliably estimates the percentage of overall plan members. A small CI, therefore, indicates greater precision, usually due to adequate sample sizes.

Figure 2 depicts the information presented in each chart.

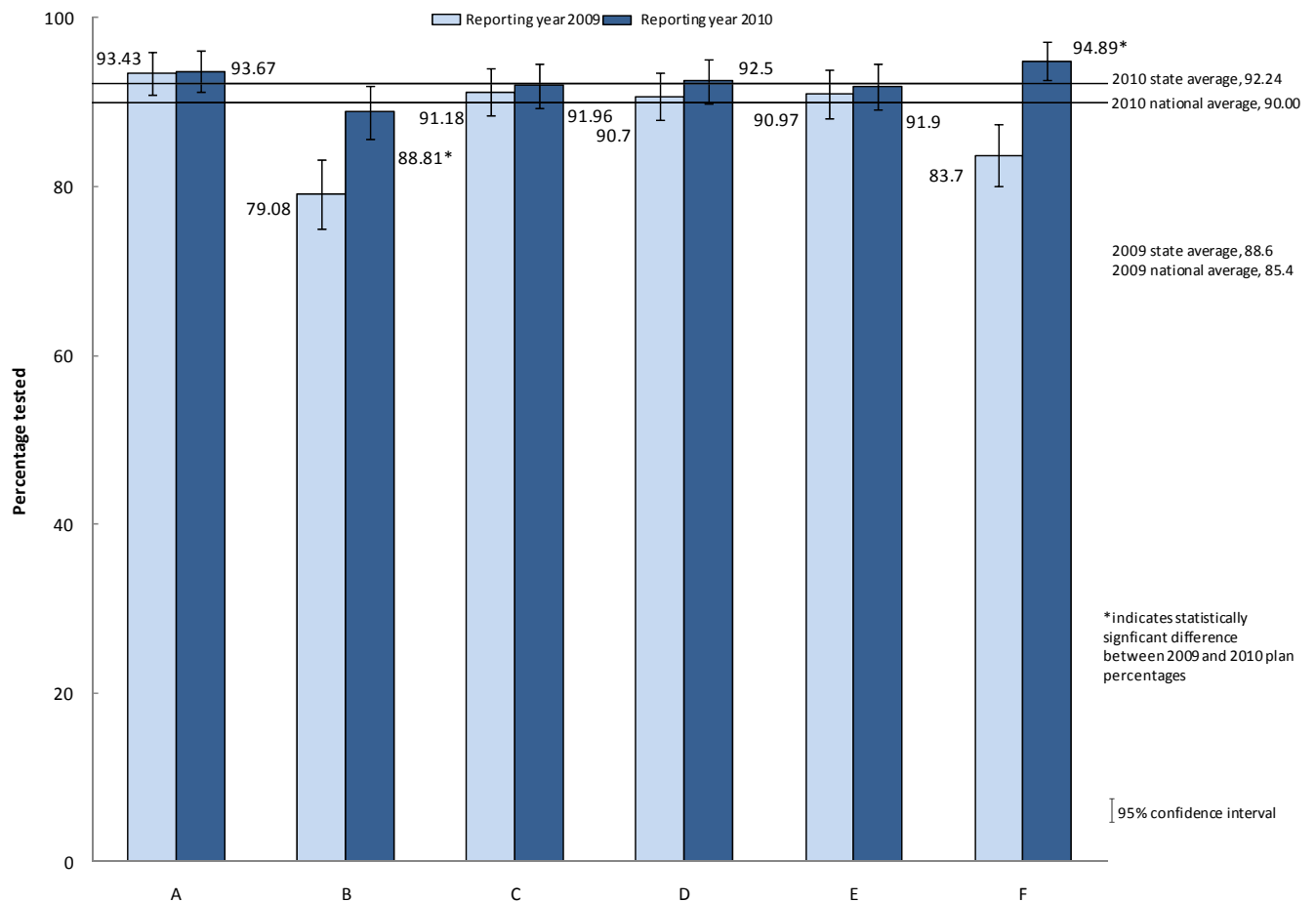


Figure 2. Sample bar chart with fabricated data.

For each health plan, Appendix A presents a summary sheet of the plan's performance on key measures and indicators, and indicates whether the plan's percentage differed significantly from the state average. An overall summary sheet compares statewide averages for each measure with the NCQA national averages.

Appendix B, published separately, presents data tables showing changes in plan, state, and national performance in each measure from reporting year 2006 through 2010.

Methods

HEDIS results for a measurement year (the year in which care is given) are gathered, audited, and reported the following year, called the reporting year. Results are based on a statistically valid random sample of health plan enrollees. The HEDIS technical specifications set stringent criteria for identifying the eligible population for each measure.¹

To ensure data integrity, NCQA verifies that a health plan collects data according to the technical specifications. Each plan's data collection process is audited by an NCQA-certified HEDIS auditor. The NCQA HEDIS Compliance AuditTM assures purchasers and health plans of fair and accurate comparisons of plan performance. MPA funds the HEDIS audit for Healthy Options plans to fulfill the federal requirement for validation of state performance measures.

Acumentra Health compiled individual plan data for the tables and charts in this report from the NCQA-audited Interactive Data Submission System (IDSS) results.² Plans with denominators of fewer than 30 eligible enrollees are identified as such, as are plans that did not report the measure in the reporting year.

Acumentra Health calculated the state average for each measure and indicator by adding individual plan numerators and denominators, dividing the aggregate numerator by the aggregate denominator, and multiplying the resulting proportion by 100. The 2010 national Medicaid averages came from NCQA's *Quality Compass*[®] report, based on data from more than 150 Medicaid managed care health plans.³

For the WMIP program, MHW reported seven HEDIS measures for 2010: comprehensive diabetes care, inpatient care utilization—general hospital/acute care and nonacute care, ambulatory care utilization, anti-depression medication management, follow-up after hospitalization for mental illness, and use of high-risk medications for the elderly. As part of the 2010 HEDIS audit for MHW, the WMIP program underwent a certified HEDIS audit that incorporated the validation of performance measures and the Centers for Medicare & Medicaid Services' Information Systems Capabilities Assessment tool. MHW also calculated four non-HEDIS measures for the WMIP: chronic dementia, falls, depression, and transition of care. The results of those four measures are not analyzed in this report.

Note: HEDIS measures are not designed for case-mix adjustment or risk adjustment for existing co-morbidities, physical or mental disabilities, or severity of disease. Therefore, when reviewing and comparing plan performance, it may be difficult to determine whether differences among plan rates were due to differences in the use of services or quality of care, or to differences in the health of the plan's population.

Administrative vs. hybrid data collection

For four measures—childhood immunizations, postpartum care, WCC visits, and diabetes care—the HEDIS technical specifications allow a health plan to collect data by the administrative or the hybrid method. In the administrative method, a plan identifies the eligible population and uses data from its information systems—such as claims and encounter data—to identify enrollees who received the service(s) for the measure. This method is cost-efficient, but can produce lower rates if providers submit incomplete data. In the hybrid method, a health plan performs supplemental medical chart reviews to identify enrollees who received the service(s) but whose services were

not represented in the administrative data. Regardless of the data collection method, eligible enrollees who received services are counted as “numerator events.”

When the hybrid method is used for calculating HEDIS rates, health plans can minimize the use of expensive medical chart review by capturing a greater percentage of numerator events through valid administrative data. Plans that supplement their administrative data with chart review may boost the number of numerator events and raise their scores on those measures. A sample of hybrid numerator events is validated as part of the HEDIS audit process.

For the past several years, Acentra Health has analyzed and reported on the difference between HEDIS rates calculated through the administrative vs. the hybrid method. The analysis for 2010 revealed essentially the same pattern as in previous years. That is, collecting data from medical charts boosted the statewide average rates by up to 65 percentage points (compared with the rates that would have been reported from administrative data only) for these measures:

- childhood immunizations—IPV, DTaP, PCV, Hep B, Combo 2, and Combo 3 (up to 21 percentage points)
- diabetes—dilated retinal exams, LDL-C <100 mg/dL, blood pressure <130/90 mm Hg, <140/90 mm Hg (up to 65 percentage points)
- WCC visits—infants; postpartum care visits (up to 22 percentage points)

Certain other measures, including WCC visits for children and adolescents, showed gains ranging from 2 to 6 percentage points due to collection of medical chart data. Administrative-only rates for most measures, however, are realizing slight increases each year.

Member-level data analysis

MPA required the Healthy Options plans to submit de-identified member-level data (including elements for gender, primary language, race/ethnicity, and county) on childhood immunizations for 2009 and 2010, and on WCC visits for 2010. Acentra Health received enough data to analyze and report differences in performance by DSHS region, gender, primary language, and race/ethnicity. Detailed results appear in the immunization and WCC sections of the report. The DSHS regions are listed on page 22.

In analyzing the member-level data, Acentra Health analysts first checked each data field submitted by each health plan for missing and out-of-range data. Certain fields should have no missing data, such as the field indicating whether a person can or cannot be counted in the numerator for a measure. Fields indicating race, ethnicity, and language preference should have only a small range of discrete values.

As an additional check, Acentra Health calculated the rate for each immunization and WCC measure, using the “clean” member-level data, then compared these calculations with the rates the plans reported in the IDSS. In the case of any difference, analysts contacted the health plans to resolve the discrepancy.

Analysts then aggregated the plan-level data sets into a single data set, and used SAS software to calculate rates by region, race, ethnicity, language preference, and urban and rural location.

Childhood Immunization Status

Childhood immunizations are one of the most effective ways to prevent and control potentially serious childhood diseases such as diphtheria, polio, rubella, mumps, and pneumococcal disease. The use of these vaccines in the United States has eliminated smallpox and polio and has virtually eliminated measles, rubella, and *Haemophilus influenzae* type b (HiB). According to the Centers for Disease Control and Prevention (CDC), if immunization practices ceased, most infectious diseases now prevented by vaccines would reemerge as serious health threats. Table 2 shows the impact of immunizations in reducing cases of childhood disease.

Table 2. Impact of childhood immunizations in the United States.⁴

Disease	Baseline 20 th century annual cases	2008 cases	Percent decrease
Measles	503,282	55	99.9%
Diphtheria	175,885	0	100.0%
Mumps	152,209	454	95.7%
Pertussis	147,271	10,735	92.7%
Smallpox	48,164	0	100.0%
Rubella	47,745	11	99.9%
HiB, invasive	20,000	30	99.9%
Polio	16,316	0	100.0%
Tetanus	1,314	19	98.6%

Childhood vaccines are among the most cost-effective clinical preventive services and one of the few services that save more money, in terms of the preventable burden, than the cost incurred.⁵ DTaP, Td, HiB, IPV, MMR, Hep B, and VZV vaccines result in annual direct cost savings of almost \$10 billion and societal cost savings (including indirect costs) of \$43.3 billion.⁶

For 2010, HEDIS added three vaccines—hepatitis A, rotavirus, and influenza—to the list of immunization indicators, plus an additional seven combinations of vaccines (Combos 4 to 10). (See “Measure definition” below). Hepatitis A is contagious and can spread through poor personal hygiene and contaminated food and water. Symptoms can include fatigue, fever, joint pain, abdominal pain, and jaundice. In rare cases, hepatitis A can cause liver failure and death.⁷ Rotavirus causes vomiting and severe diarrhea. Before the initiation of the rotavirus vaccine program in 2006, approximately 55,000 children were hospitalized annually in the United States.⁸ Seasonal flu, a contagious respiratory illness, can be mild to severe. Symptoms can include high fever, fatigue, headache, and muscle aches. Young children are at increased risk for complications such as bacterial pneumonia, ear infections, sinus infections, and dehydration.⁹

County and state health organizations throughout Washington use the Department of Health’s (DOH) CHILD Profile immunization registry. In September 2010, 91 percent of all vaccination providers in the state—up from 87 percent a year earlier—participated in CHILD Profile. The registry contained more than 6.5 million immunization records, including at least two records for 94 percent of children under age 6. In addition, 240 school districts now participate, covering 97 percent of the statewide student enrollment. CHILD Profile exchanges data with Oregon, Idaho, Arizona, and Louisiana.

Health plans submit claims data monthly, quarterly, or annually, and receive updated registry data during the winter to augment their data collection for the HEDIS immunization measure. All plans take part in activities to increase awareness and use of the registry.

As of May 1, 2010, the State of Washington ceased paying for vaccines for children with private health insurance. State-supplied vaccines are purchased only for those eligible for the federal Vaccines for Children program, and for children in families below 300 percent of the federal poverty level who are enrolled in state-sponsored health programs. To help the state continue its universal purchase of vaccines for children under age 19, the legislature created the Washington Vaccine Association (WVA), an independent nonprofit organization, to administer the flow of vaccine funds. The WVA collects payments from health plans, insurers, and other payers and remits the funds to DOH to cover the cost of vaccines for privately insured children. Through DOH's Childhood Vaccine Program, the state buys vaccines at federal contract rates and distributes them to providers at no charge. Private practice physicians now administer about 90 percent of all childhood immunizations. Since May 1, the WVA has provided \$7.2 million for vaccines administered to privately insured children in Washington.¹⁰

AFIX (Assessment, Feedback, Incentives, and Exchange) is the CDC's quality improvement (QI) tool for raising immunization coverage levels and improving practice standards at the provider level. State immunization programs have used the AFIX methodology in public health clinics that administer childhood immunizations, even as the bulk of immunization services have shifted to the private sector. The CDC recommends that federally funded immunization programs conduct annual AFIX site visits in at least 25 percent of provider offices.¹¹ The Washington State DOH conducts AFIX visits in conjunction with CHILD Profile.

Measure definition

This measure assesses the percentage of enrolled children who turned two years old during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthday, and who received the following vaccinations:

- four diphtheria, tetanus, and acellular pertussis (DTaP)
- three polio (IPV)
- one measles, mumps, and rubella (MMR)
- two *Haemophilus influenzae* type b (HiB)
- three hepatitis B (Hep B)
- one varicella-zoster virus (VZV)
- four pneumococcal conjugate (PCV)
- two hepatitis A (Hep A) **NEW**
- two or three rotavirus (RV) **NEW**
- two influenza (flu) **NEW**
- Combination #2 (Combo 2) includes all antigens listed above except for PCV; received four
- Combination #3 (Combo 3) includes all antigens listed above; received four
- Combination #4 (Combo 4) includes Combo 3 plus Hep A **NEW**
- Combination #5 (Combo 5) includes Combo 3 plus RV **NEW**
- Combination #6 (Combo 6) includes Combo 3 plus flu **NEW**
- Combination #7 (Combo 7) includes Combo 3 plus Hep A and RV **NEW**
- Combination #8 (Combo 8) includes Combo 3 plus Hep A and flu **NEW**
- Combination #9 (Combo 9) includes Combo 3 plus RV and flu **NEW**
- Combination #10 (Combo 10) includes Combo 3 plus Hep A, RV and flu **NEW**

Data collection method: Administrative or hybrid

Trends for all immunizations

Figure 3 shows the Healthy Options state averages for seven separate immunizations and for the Combo 2 and Combo 3 indicators for reporting years 2006–2010. The 2010 results indicate a continuing stabilization of statewide immunization rates, except that the vaccination rates for Hep B, Combo 2, and Combo 3 rose significantly from 2009. The 2010 statewide rates for Hep B, IPV, PCV, and Combo 2 and 3 were significantly above the national average, while the statewide rate for VZV was significantly below the national average.

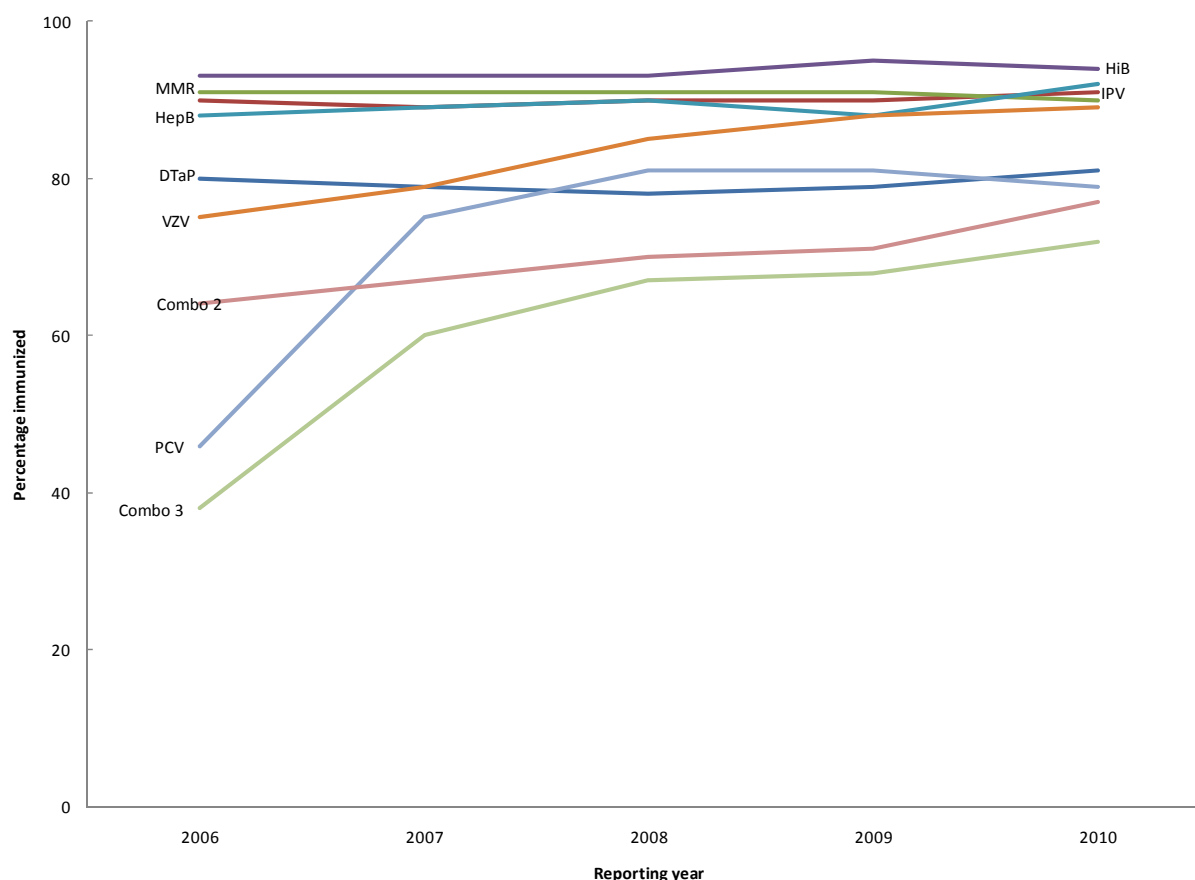


Figure 3. State averages for seven immunizations, Combo 2, and Combo 3, reporting years 2006–2010.

The federal benchmark report, *Healthy People 2010*, sets 80 percent as the target for health plans to achieve by 2010 for DTaP, IPV, MMR, HiB, and Hep B, and 90 percent as the target for PCV.¹² Currently, the statewide averages for all individual antigens except PCV are above 80 percent. Improvement in the PCV vaccination rate has stalled, leaving this indicator well below the federal benchmark, though still significantly higher than the national Medicaid average. The CDC is developing *Healthy People 2020* objectives, along with guidance for achieving the new 10-year targets.¹³

Diphtheria, Tetanus, and Pertussis (DTaP)

The 2010 statewide average for this indicator was 80.74 percent, slightly higher than the 2009 rate; the median in 2010 was 81.25 percent. Once again, RBS's DTaP immunization rate significantly exceeded the state average in 2010, while CUP's rate remained significantly below average, even after a significant increase during the year. The Healthy Options average was above the national average of 79.53 percent, although the difference was not significant. Figure 4 shows that four plans had percentages above the 2010 national average.

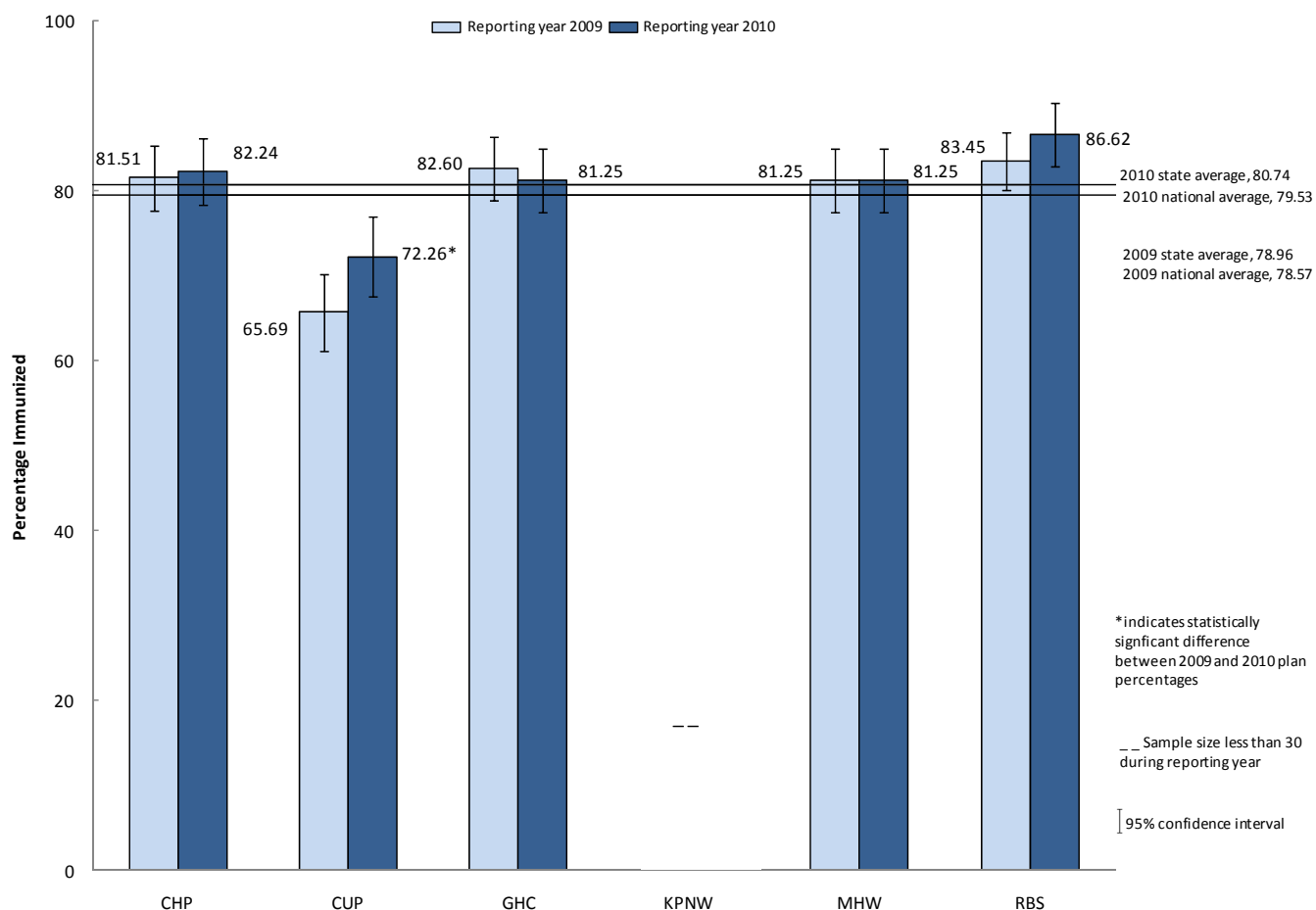


Figure 4. DTaP immunizations by health plan, reporting years 2009–2010.

California's Department of Public Health reported in June 2010 that the state's pertussis (whooping cough) epidemic was on track to be the worst in 50 years, with a fourfold increase in pertussis cases since the previous year and, though mid-June, five deaths of infants under three months of age.¹⁴ The Washington DOH reported two infant deaths from pertussis through mid-September 2010.

Inactivated Polio Vaccine (IPV)

The 2010 statewide average for this indicator was 90.68 percent, slightly higher than 2009's 89.89 percent; the median in 2010 was 91.67 percent. Figure 5 shows that four plans scored higher than the 2010 national average of 88.96 percent; the Healthy Options average was significantly higher than the national average. CUP's rate, however, was significantly below the state average. The state average has improved significantly since 2004.

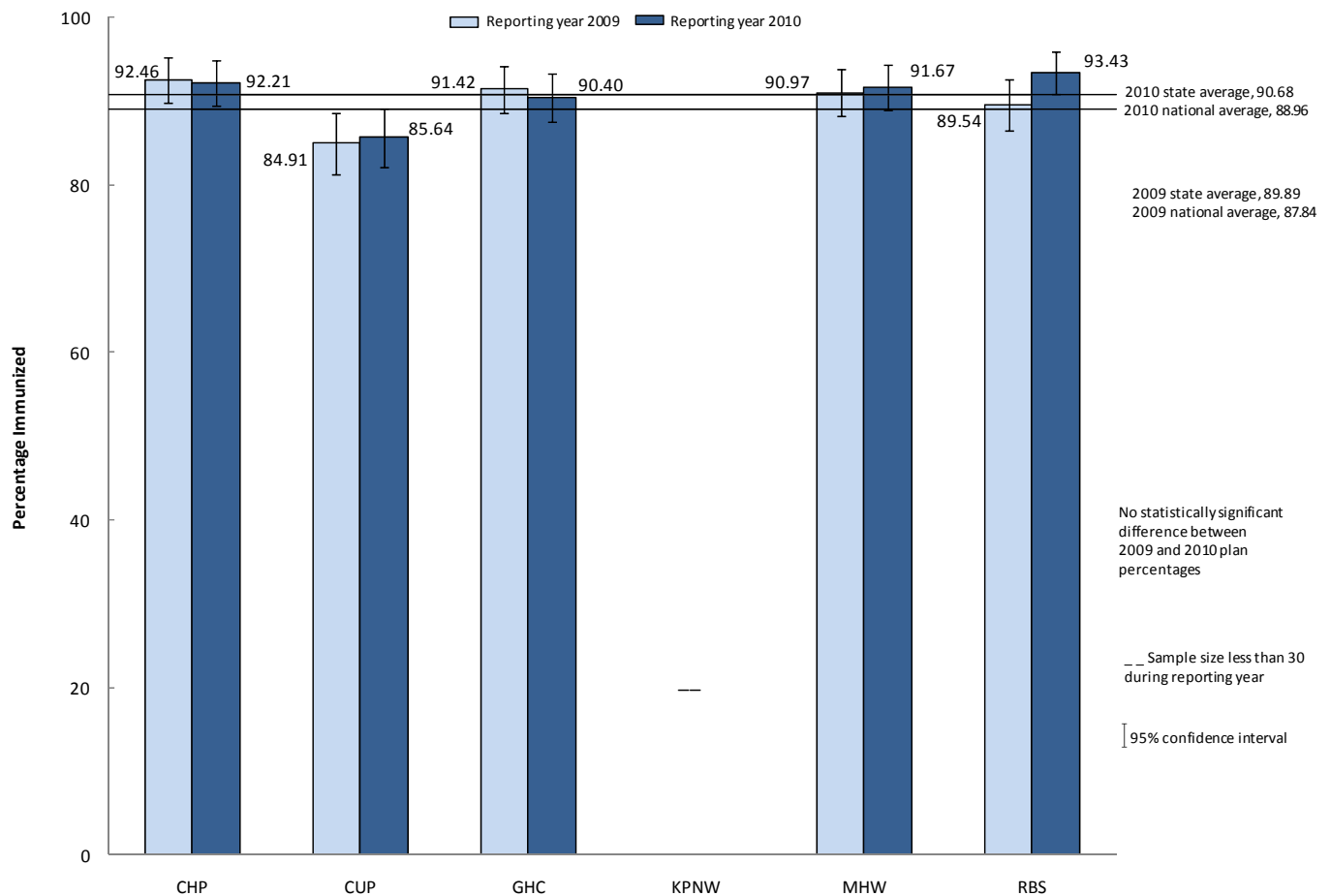


Figure 5. IPV immunizations by health plan, reporting years 2009–2010.

Measles, Mumps, and Rubella (MMR)

The 2010 statewide average for this indicator was 90.39 percent, slightly below the 91.22 percent average in 2009; the median in 2010 was 90.97 percent. As shown in Figure 6, three plans scored above 90 percent. The state average was lower than the national average of 91.15 percent, though not significantly lower. Once again, RBS significantly outperformed the state average, while CUP's rate was significantly below average. The state average has dipped in the past three years and is now the lowest since 2007.

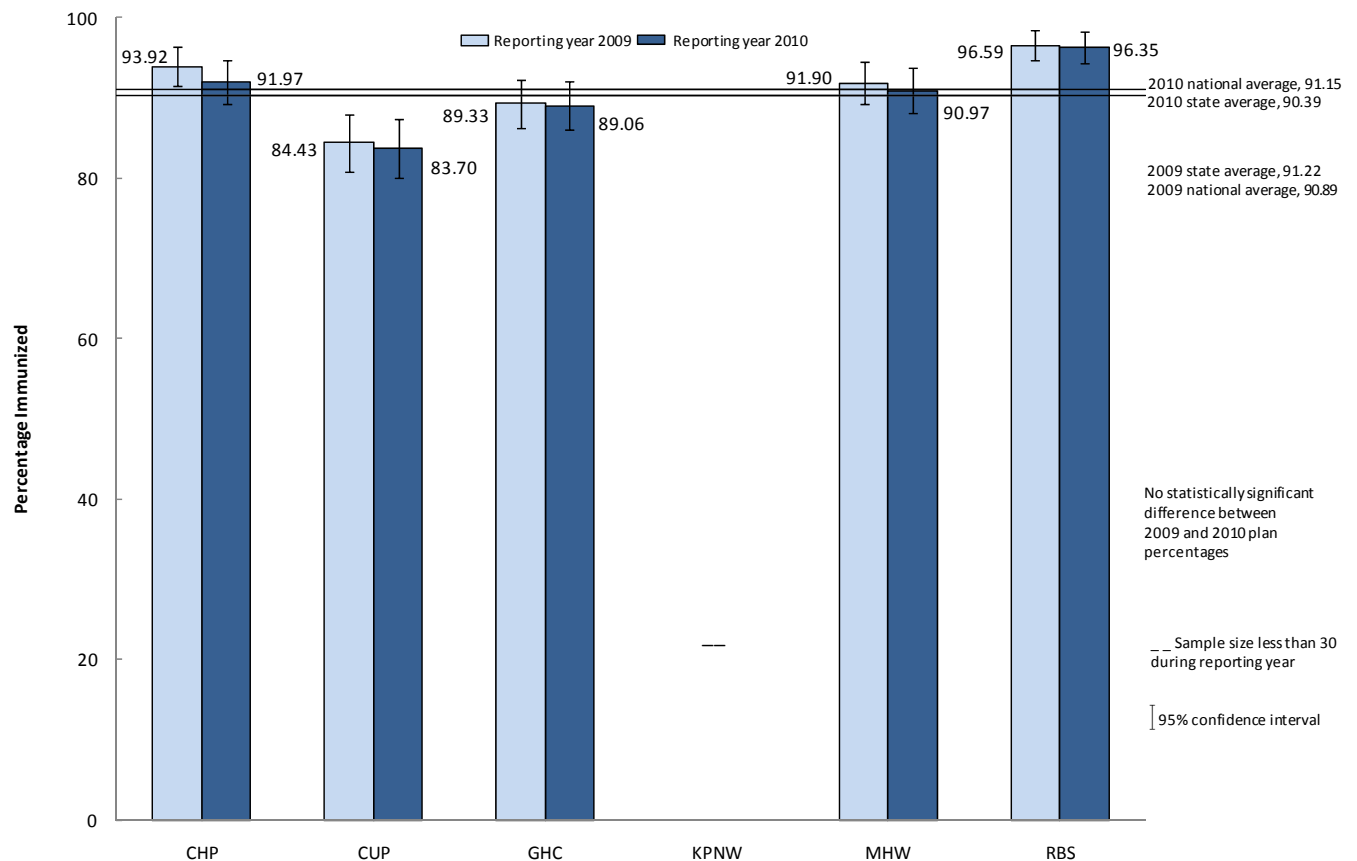


Figure 6. MMR immunizations by health plan, reporting years 2009–2010.

Haemophilus Influenzae Type B (HiB)

The 2010 statewide average for this indicator was 94.37 percent, slightly below the 94.66 percent average in 2009; the median in 2010 was 95.60 percent. As shown in Figure 7, three plans' percentages exceeded the 2010 national average of 93.70 percent, the state average being above the NCQA average but not significantly higher. RBS reported the highest rate among Healthy Options plans (almost 97 percent), while CUP's rate remained significantly below the statewide average. The statewide HiB rate has increased by more than 10 percentage points since 2004.

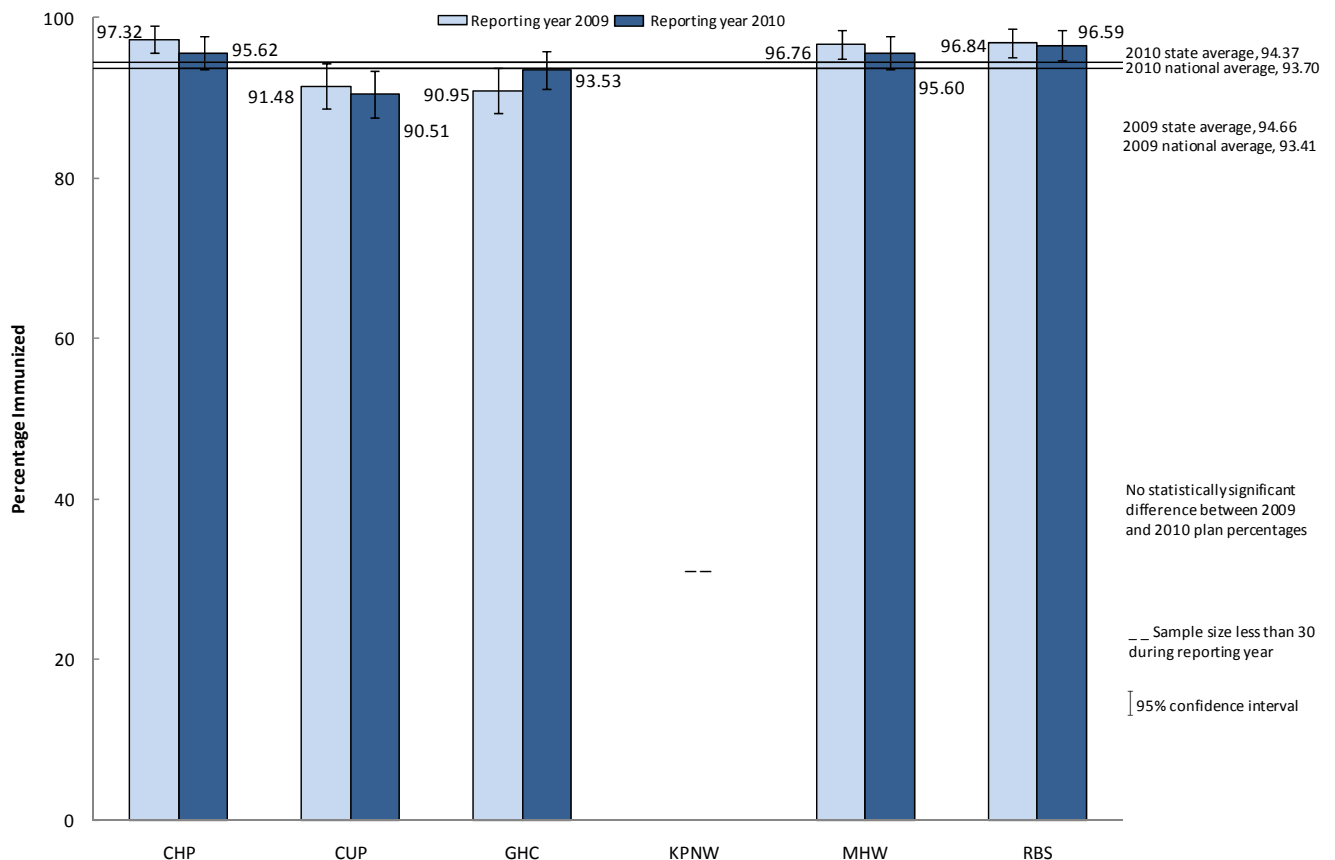


Figure 7. HiB immunizations by health plan, reporting years 2009–2010.

Hepatitis B (Hep B)

The 2010 statewide average for this indicator was 92.24 percent, up significantly from 87.84 percent in 2009; the median in 2010 was 91.96 percent. This is the highest statewide percentage in the past five years. Both CUP and RBS reported statistically significant increases in 2010, though CUP's percentage remained significantly lower than the state average. Figure 8 shows that four of the plan percentages were above the 2010 national average of 89.04 percent, the state average being significantly above the NCQA average.

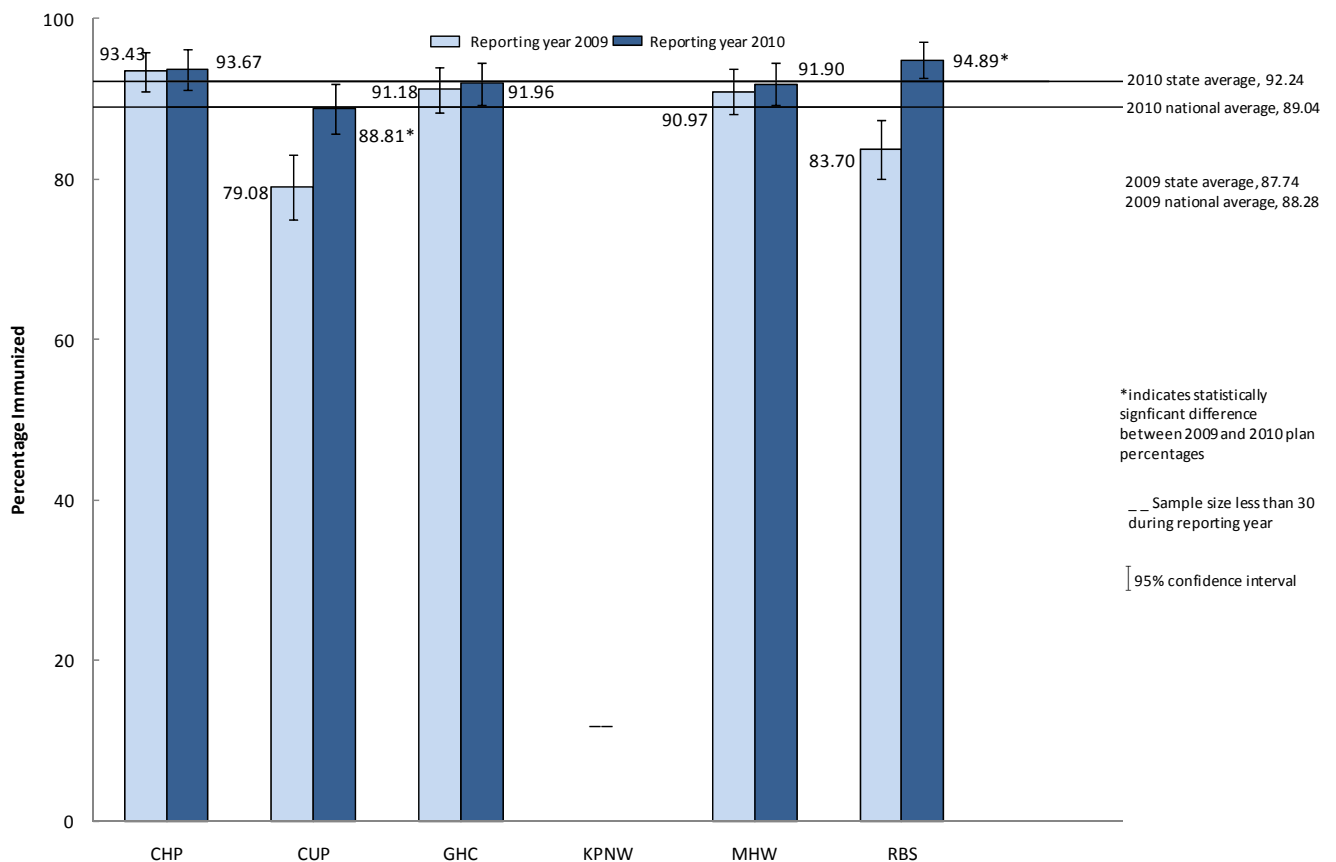


Figure 8. Hep B immunizations by health plan, reporting years 2009–2010.

Varicella-Zoster Virus (VZV)

The 2010 statewide average for this indicator was 89.21 percent, slightly higher than the 2009 rate of 88.41 percent; the median in 2010 was 89.58 percent. RBS's rate, despite dipping in 2010, remained significantly above the statewide average, while CUP's was significantly below average. Figure 9 shows that RBS exceeded the 2010 national average of 90.54 percent, while other Healthy Options plans were below the national average. The state average remained significantly below the NCQA average.

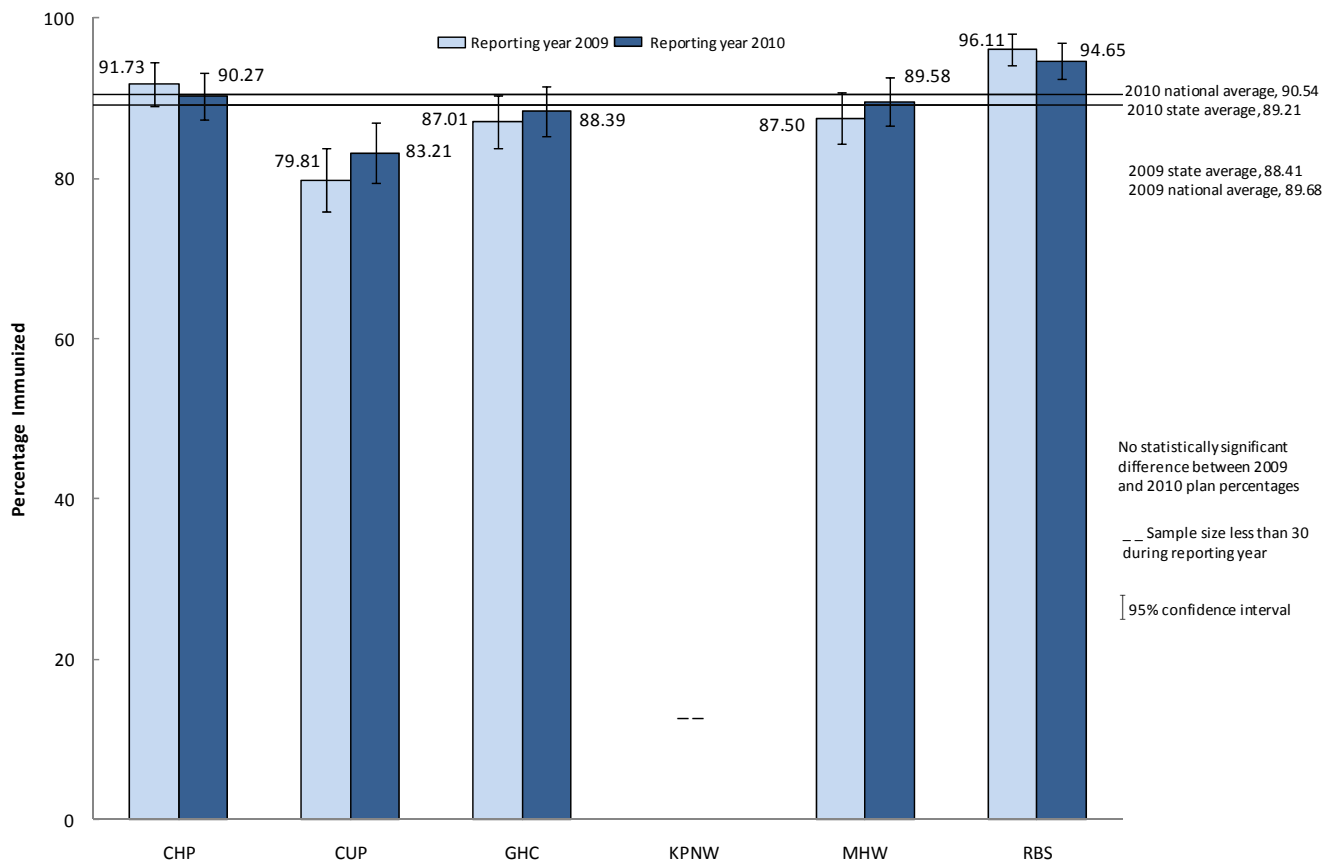


Figure 9. VZV immunizations by health plan, reporting years 2009–2010.

Pneumococcal Conjugate (PCV)

The 2010 statewide average for this indicator was 79.46 percent, slightly below the 2009 average; the median in 2010 was 82.24 percent. Figure 10 shows that RBS's rate was significantly higher than the state average, while CUP's rate was significantly below average. The state average was significantly above the national average of 77.56 percent.

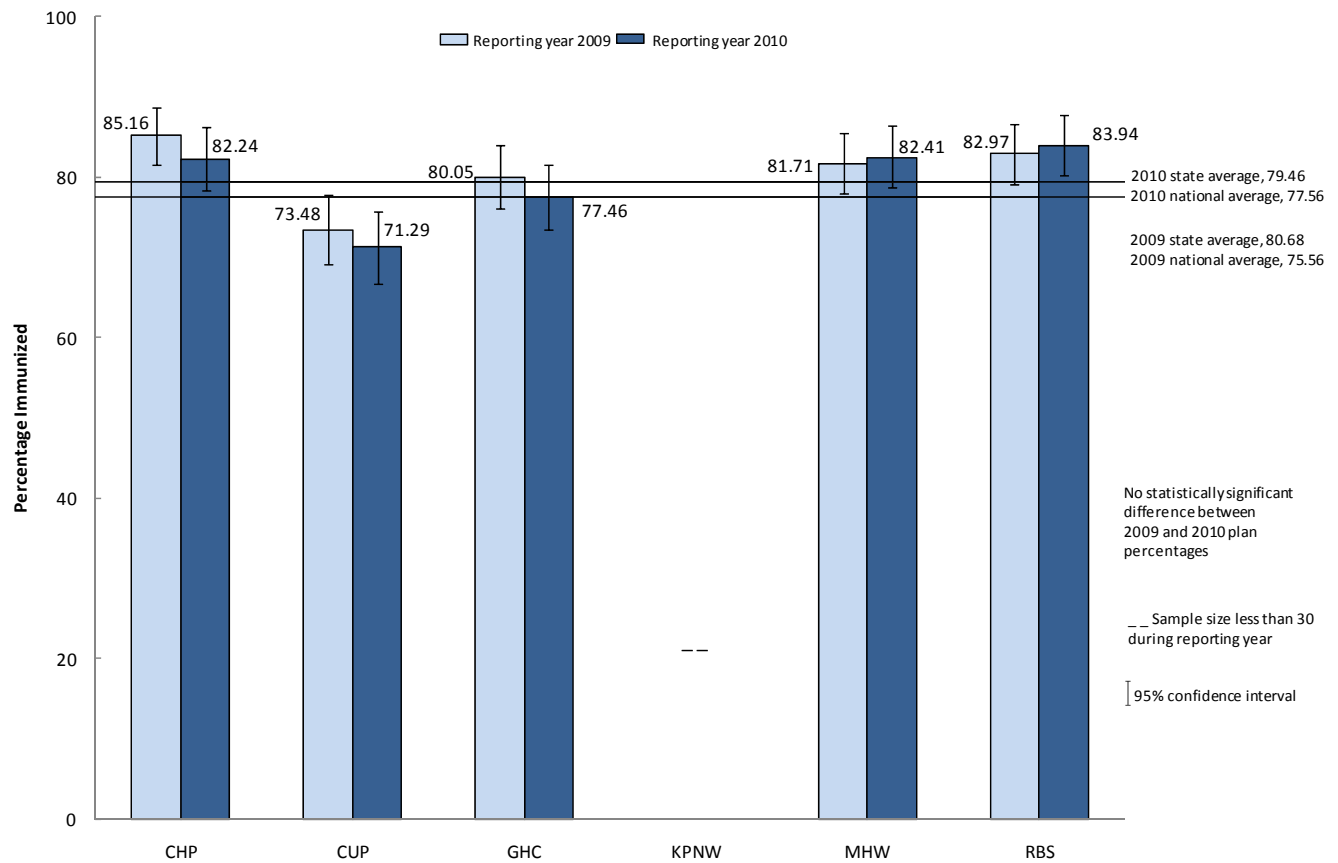


Figure 10. PCV immunizations by health plan, reporting years 2009–2010.

Combination #2 (Combo 2)

The 2010 statewide average for this combined indicator was 76.72 percent, significantly above the 71.37 percent average in 2009; the median in 2010 was 77.31 percent. Figure 11 shows that RBS's rate was significantly higher than the state average, while CUP's rate was significantly below average. The Healthy Options average was significantly higher than the 2010 national average of 74.20 percent. The state average has risen consistently from 64 percent in 2006 to its present level.

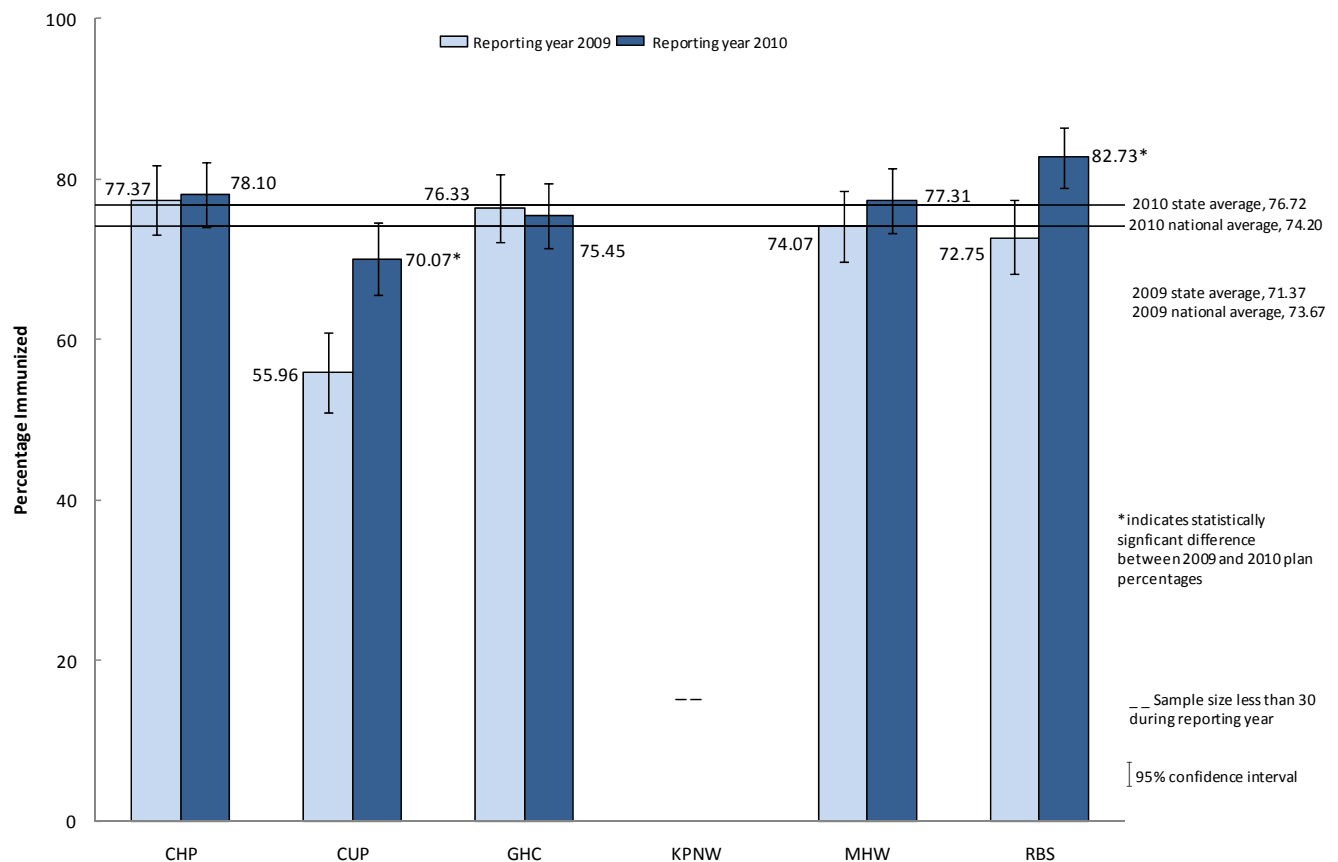


Figure 11. Combo 2 immunizations by health plan, reporting years 2009–2010.

Combination #3 (Combo 3)

The 2010 statewide average for this indicator was 71.6 percent, significantly higher than the 67.6 percent average in 2009; the median in 2010 was 73.61 percent. Figure 12 shows that RBS and CUP raised their Combo 3 rates significantly from 2009. The state average was significantly above the 2010 national average of 69.29 percent, and has risen by more than 30 percentage points since the inception of this measure in 2006.

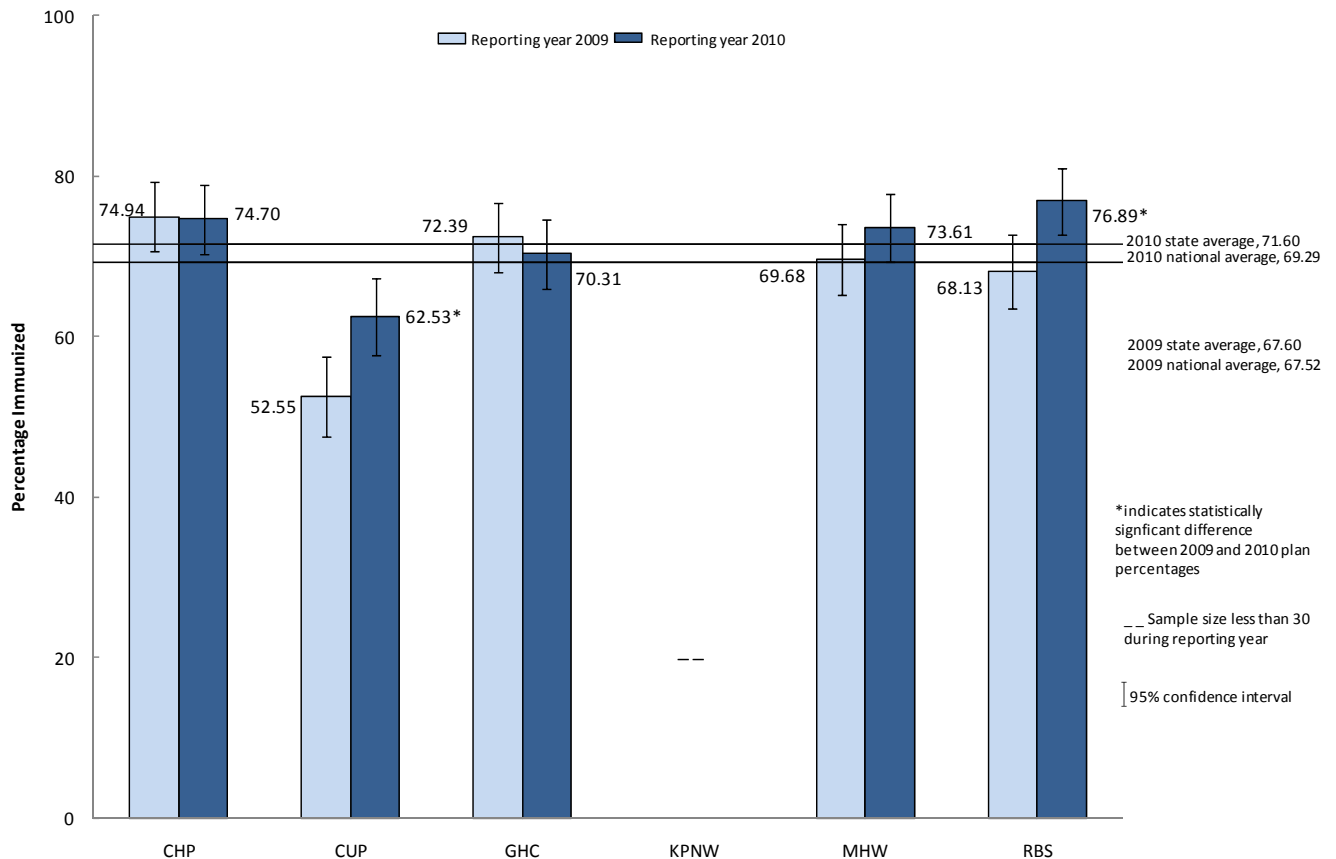


Figure 12. Combo 3 immunizations by health plan, reporting years 2009–2010.

New measures

Healthy Options plans reported the following measures for the first time in 2010. National averages are not reported for these first-year measures in the NCQA *Quality Compass*.

Hepatitis A: The 2010 statewide average was 39.96 percent; the median was 34.03 percent. GHC's rate was statistically higher than the state average, while CUP's and RBS's rates were significantly below average.

Rotavirus: The 2010 statewide average was 26.03 percent; the median was 29.63 percent. CHP's rate was significantly higher than the state average, while CUP's rate was significantly below average.

Influenza: The 2010 statewide average was 40.51 percent; the median was 43.53 percent. CUP's rate was significantly lower than the state average.

NCQA introduced seven new combination measures incorporating the newly reported antigens (for definitions of these measures, see page 10).

Combo 4: The 2010 statewide average for this new measure was 33.36 percent; the median was 31.71 percent. GHC's rate was significantly higher than the state average, while CUP's and RBS's rates were significantly below average.

Combo 5: The 2010 statewide average was 22.76 percent; the median was 26.39 percent. CUP's rate was significantly lower than the state average.

Combo 6: The 2010 statewide average was 35.68 percent; the median was 39.17 percent. CUP's rate was significantly lower than the state average.

Combo 7: The 2010 statewide average was 11.45 percent; the median was 12.73 percent. GHC's rate was significantly higher than the state average, while CUP's rate was significantly below average.

Combo 8: The 2010 statewide average was 19.21 percent; the median was 19.44 percent. GHC's rate was significantly higher than the state average, while CUP's and RBS's rates were significantly below average.

Combo 9: The 2010 statewide average was 12.97 percent; the median was 13.87 percent. CUP's rate was significantly lower than the state average.

Combo 10: The 2010 statewide average was 7.05 percent; the median was 7.79 percent. GHC's rate was significantly higher than the state average, while CUP's rate was significantly below average.

Member-level data analysis

MPA required the Healthy Options plans to submit de-identified member-level data on childhood immunizations for 2009 and 2010. Acumentra Health received enough data to analyze and report differences in performance by DSHS region, gender, primary language, and race/ethnicity. The DSHS regions are configured as shown below.

Region	Counties
1	Adams, Asotin, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Whitman
2	Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima
3	Island, San Juan, Skagit, Snohomish, Whatcom
4	King
5	Kitsap, Pierce
6	Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, Wahkiakum

- **Rates by region:**
 - Region 2 significantly outperformed every other region in 8 of the 19 vaccines or combinations (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, and Combo 2).
 - Region 5 significantly outperformed all other regions in two of the three newly reported vaccines (Hep A and Influenza) and in all of the seven new combinations. Notably, 54.33 percent of Region 5 enrollees received the Hep A vaccine.
 - Region 4's rate for the Rotavirus vaccine (33.33 percent) was significantly higher than the other regions combined.
 - Region 6 rates were lower than every other region in 18 of the 19 antigens or combinations (all but Hep B)—significantly lower for 17 indicators.
- **Rates by gender:**
 - Immunization rates for Rotavirus and Combo 5 (includes Rotavirus) were significantly higher for males than for females.
- **Rates by primary language:**
 - Spanish-speaking enrollees had significantly higher immunization rates than Russian and English speakers for 11 of the 19 antigens or combinations.
 - Russian-speaking enrollees had significantly lower immunization rates than English and Spanish speakers for 11 of the 19 indicators.
- **Rates by race/ethnicity:**
 - For 5 of the 19 antigens or combinations, Asians were immunized at significantly higher rates compared with African-American and White enrollees. All 32 Asians in the member-level sample received the MMR vaccine. Asian enrollees also had the

- highest immunization rates for the three newly reported vaccines and for six of the seven new combinations.
- Immunization rates were higher for the Hispanic vs. the non-Hispanic population for all vaccines—significantly higher in 15 of the 19 indicators.
- **Rates by urban/rural:**
 - As a group, enrollees living in urban areas were immunized at higher rates compared with those living in rural locations for all antigens and combinations—significantly higher for 17 of the 19 indicators.

Discussion

The long-term trend of immunization rates has been clearly positive, as shown for Combo 2 and Combo 3. However, results for childhood immunization indicators were mixed in reporting year 2010. The statewide Hep B immunization rate rose significantly, as did the rates for Combo 2 and Combo 3, but rates for other vaccines showed signs of leveling off. RBS outperformed all other Healthy Options plans on all indicators, and CHP was a strong performer as well. As a group, the Healthy Options plans significantly outperformed the national average for Hep B, IPV, PCV, and Combo 2 and 3.

The Healthy Options plans' favorable performance, relative to the national averages for most indicators, should not lead to complacency. "Herd immunity" exists when a group resists attack by a disease because a large number of individuals are immune; the more immune individuals, the less likely it is that a susceptible person will come into contact with someone who has the disease. Nevertheless, outbreaks of disease can and do occur even when a high level of herd immunity is reached.¹⁵ The Healthy Options plans need to continue to seek ways to increase their immunization rates.

As reported in the 2010 NCQA *Quality Compass*, Combo 2 and 3 immunization rates in the Pacific Region (Alaska, Washington, Oregon, California, and Hawaii) lagged behind the top-performing region. The New England Region, the top performer for all immunizations, reported average rates of 79.52 percent for Combo 2 and 76.46 percent for Combo 3, compared with 77.78 percent and 72.96 percent for the Pacific Region, respectively. The South Atlantic Region reported the lowest rates, 69.83 percent for Combo 2 and 64.60 percent for Combo 3.

Within Washington, member-level data analysis indicates that, depending on the vaccine, immunization rates were highest in south central Washington (Region 2), the Tacoma area (Region 5), or King County (Region 4); the lowest immunization rates for almost all antigens and combinations occurred in western and southwestern counties (Region 6). With regard to primary language, for the majority of antigens and combinations, immunizations were highest among Spanish-speaking enrollees and lowest among Russian speakers. Asian enrollees tended to have higher immunization rates than other racial groups, while Hispanic enrollees were immunized at higher rates compared with non-Hispanic enrollees. Urban dwelling enrollees were immunized at significantly higher rates than rural dwellers for most indicators.

Increasing use of the CHILd Profile registry and contractual incentives for performance improvement have contributed to long-term success in improving immunization rates. MPA implemented the performance incentive program in 2005; however, because of current budget constraints, the state legislature has defunded the incentive program.

According to the CDC, the following themes have emerged in states with the highest immunization rates:

- ensuring the effectiveness of AFIX
- fostering strong leadership and senior management support
- establishing partnerships (i.e., private providers, local-state, finding “common ground”)
- creating consistent provider education and communication programs
- sustaining passionate and competent program staff
- building and sustaining community trust and involving community stakeholders/leaders
- using immunization registries
- gaining and promoting program visibility
- developing vaccine safety education programs
- enacting immunization laws for school and child care entry
- creating parental reminder/recall systems¹⁶

In a report to the state legislature, MPA recommended these strategies for improving immunization rates:

- expand provider and parent education and strengthen quality assurance oversight activities with an enhanced AFIX program
- address the ease with which parents can exempt their children from immunizations
- conduct a research study of immunization performance to help target QI efforts
- increase the vaccine administration fee for Medicaid providers
- implement the planned Medicaid pay-for-performance mechanism for childhood immunizations¹⁷

Recommendations

Further improvement requires a long-term commitment to strategies that have proved effective, as shown by experience with Combo 2 and 3. The state and the Healthy Options plans should continue to invest in activities that lead to sustainable change, such as:

- coordinate and fund clinic-level QI projects for preventive care
- dedicate resources for unique ways to provide incentives to clinics and Medicaid enrollees to ensure that children are immunized
- perform a root-cause analysis to identify underlying problems that may interfere with children’s ability to receive the recommended antigens
- provide clinic-level performance feedback, including HEDIS administrative data on a quarterly basis
- evaluate administrative data on immunizations quarterly to monitor progress
- target unique interventions at underserved populations, such as parents of Russian-speaking children
- focus improvement efforts on new antigens and combination measures
- low-performing plans should work to identify and implement best practices used by high-performing plans

For the immunization indicators as a whole, the Healthy Options plans obtained fewer numerator “hits” from medical chart review in 2010 compared to previous years. This increased reliance on

administrative sources is in line with Acumentra Health's previous recommendations. We continue to recommend that plans

- conduct encounter validation studies to determine the completeness of encounter data, and take steps to improve the data as necessary
- conduct county-level analysis to determine patterns of lower immunization rates that may be an appropriate target for QI activities
- convene representatives to analyze data and design shared best practices

Comprehensive Diabetes Care

In 2007 (the most recent year for which information is available), diabetes affected nearly 24 million people in the United States (7.8 percent of the U.S. population, including 5.7 million undiagnosed patients), an increase of more than 3 million in about two years.¹⁸ In addition, an estimated 57 million Americans have pre-diabetes and are at increased risk for diabetes. The annual cost of diabetes in the United States is estimated at \$174 billion, including \$116 billion in medical expenditures. Diabetes was the seventh leading cause of death listed on U.S. death certificates in 2006.¹⁹

In Washington, about 7 percent of adults have been diagnosed with diabetes, up from 4 percent in 1994. Diabetes affects about 2 million state residents: 444,000 with diagnosed diabetes, more than 162,000 with undiagnosed diabetes, and 1.4 million with pre-diabetes.²⁰

Because the risk factors associated with complications from diabetes are more common in people with low incomes, early diagnosis and treatment are especially important for Medicaid enrollees.²¹ Effective monitoring and control of a patient's blood glucose and low-density lipoprotein (LDL) levels can significantly reduce the risk of developing heart disease, blindness, end-stage renal disease, stroke, and lower extremity amputation.

The eligible population for this measure is adults 18–75 years of age. Because children account for more than 80 percent of Washington's Medicaid population, health plans with low overall enrollment have difficulty finding enough adult enrollees eligible for the diabetes measures.

In reporting year 2009, NCQA introduced a new indicator of “good control” of blood glucose, defined as an HbA1c level below 8 percent. MPA required the Healthy Options plans to report the new indicator beginning in 2009. NCQA has retained its previous indicator of good control, defined as HbA1c < 7 percent, but has refined it by adding exclusions for members within a specific age cohort and with certain co-morbid conditions. MPA does not require the Healthy Options plans to report that indicator. The American Diabetes Association (ADA) currently recommends a threshold of HbA1c \geq 6.5 percent for diagnosing diabetes.²²

Measure definition

This measure assesses the percentage of enrollees with diabetes (type 1 or type 2), ages 18–75, who were continuously enrolled during the measurement year and who had:

- Hemoglobin A1c (HbA1c) level tested
- poor control of HbA1c levels (HbA1c > 9.0% or no HbA1c test)
- good control of HbA1c levels (HbA1c < 8.0%)
- lipid profile (LDL-C screening) performed during the measurement year
- LDL-C levels controlled (<100 mg/dL)
- dilated retinal exam during, or prior to, the measurement year*
- monitoring for nephropathy (kidney disease) through screening for microalbuminuria, medical attention for nephropathy, a visit to a nephrologist, a positive macroalbuminuria test, or evidence of ACE inhibitor/ARB therapy
- blood pressure control (<140/90 mm Hg) for the most recent blood pressure reading
- blood pressure control (<130/80 mm Hg) for the most recent blood pressure reading

Data collection method: Administrative or hybrid

*Dilated retinal exams performed prior to the measurement year must meet the following criteria for inclusion:

- the dilated retinal exam had a negative outcome (no evidence of retinopathy)
- the enrollee was not prescribed or dispensed insulin during the measurement year

Annual HbA1c test

The 2010 statewide average for HbA1c testing was 83.67 percent, the highest since the inception of this indicator; the median was 84.48 percent. As shown in Figure 13, all Healthy Options plans outperformed the national average of 80.61 percent, and the statewide average exceeded the national average significantly.

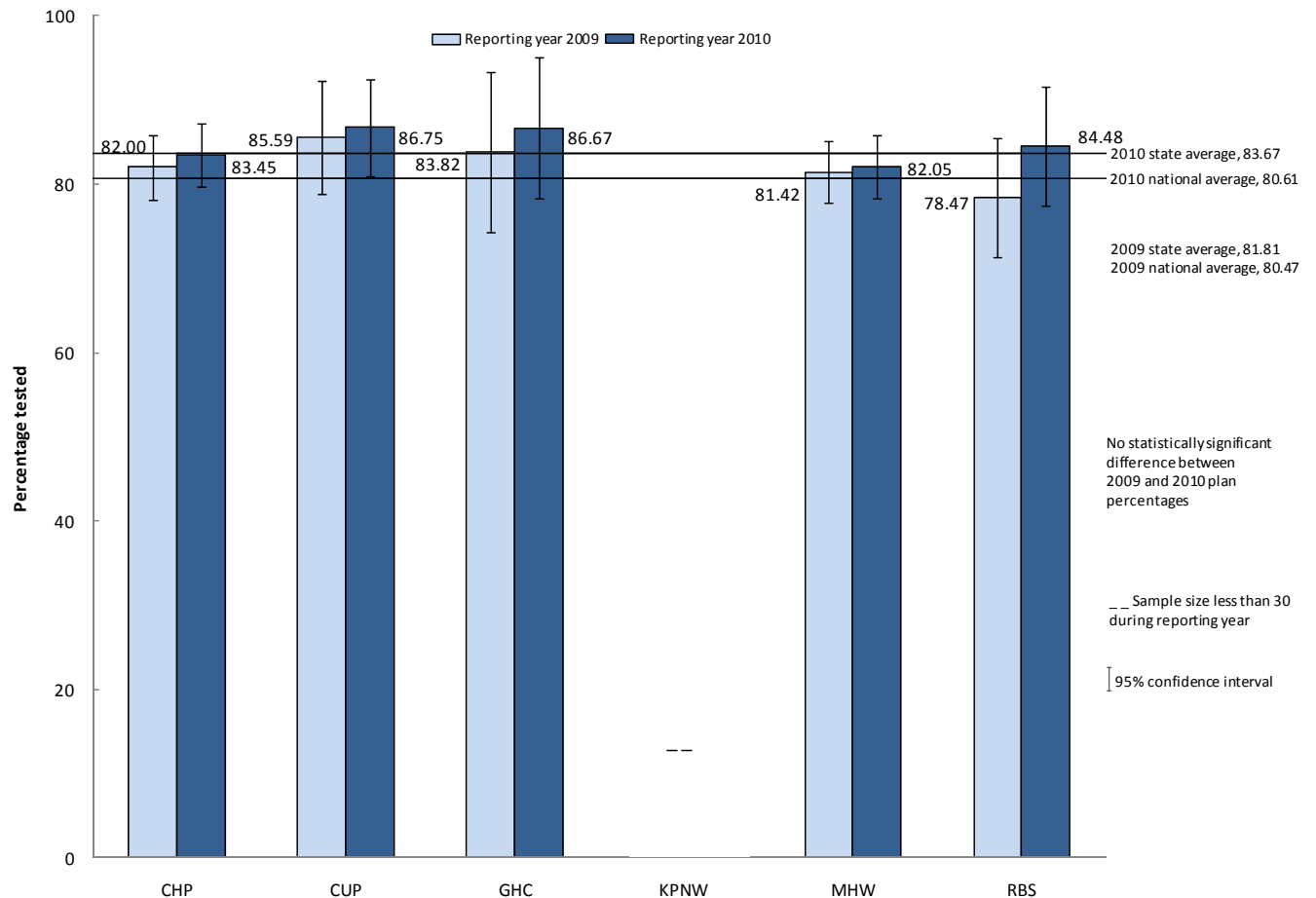


Figure 13. HbA1c tests by health plan, reporting years 2009–2010.

The HbA1c test shows the average blood glucose level from the previous two to three months. Test results are expressed as a percentage, with 4 to 6 percent considered normal. Maintaining near-normal HbA1c levels can, on average, help people with diabetes gain an extra five years of life, eight years of eyesight, and six years of freedom from kidney disease.²³

Poor HbA1c control (> 9.0%)

The 2010 plan percentages of enrollees with HbA1c levels poorly controlled ranged from a low of 36 percent (GHC) to a high of 49 percent (CUP). For this indicator, a lower percentage is favorable; thus, GHC's result was the best. Figure 14 shows that in 2010, the Healthy Options average was 45.77 percent; the median was 46.39 percent. The statewide average for this indicator has inched upward in each of the past four years and is now slightly higher (i.e., worse) than the NCQA average of 44.83 percent.

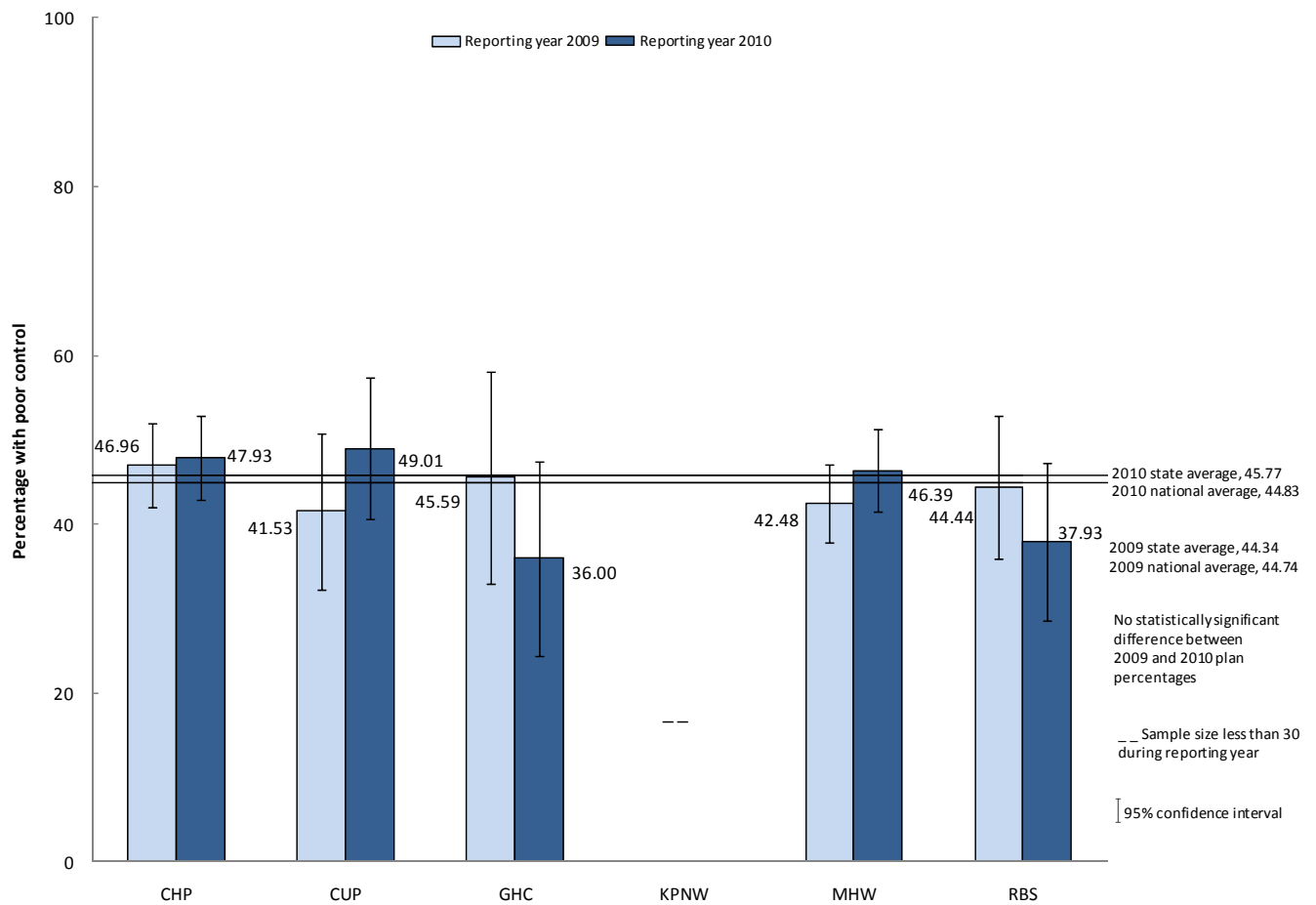


Figure 14. Enrollees with poor control of HbA1c levels by health plan, reporting years 2009–2010.

Good HbA1c control (< 8.0%)

MPA required the Healthy Options plans to report this new indicator for the first time in 2009. As Figure 15 shows, the percentage of Healthy Options enrollees with good HbA1c control averaged 44.33 percent in 2010; the median was 44.76 percent. GHC outperformed the other plans with an average of 56 percent. The statewide average was slightly below the 2010 national average of 45.70 percent.

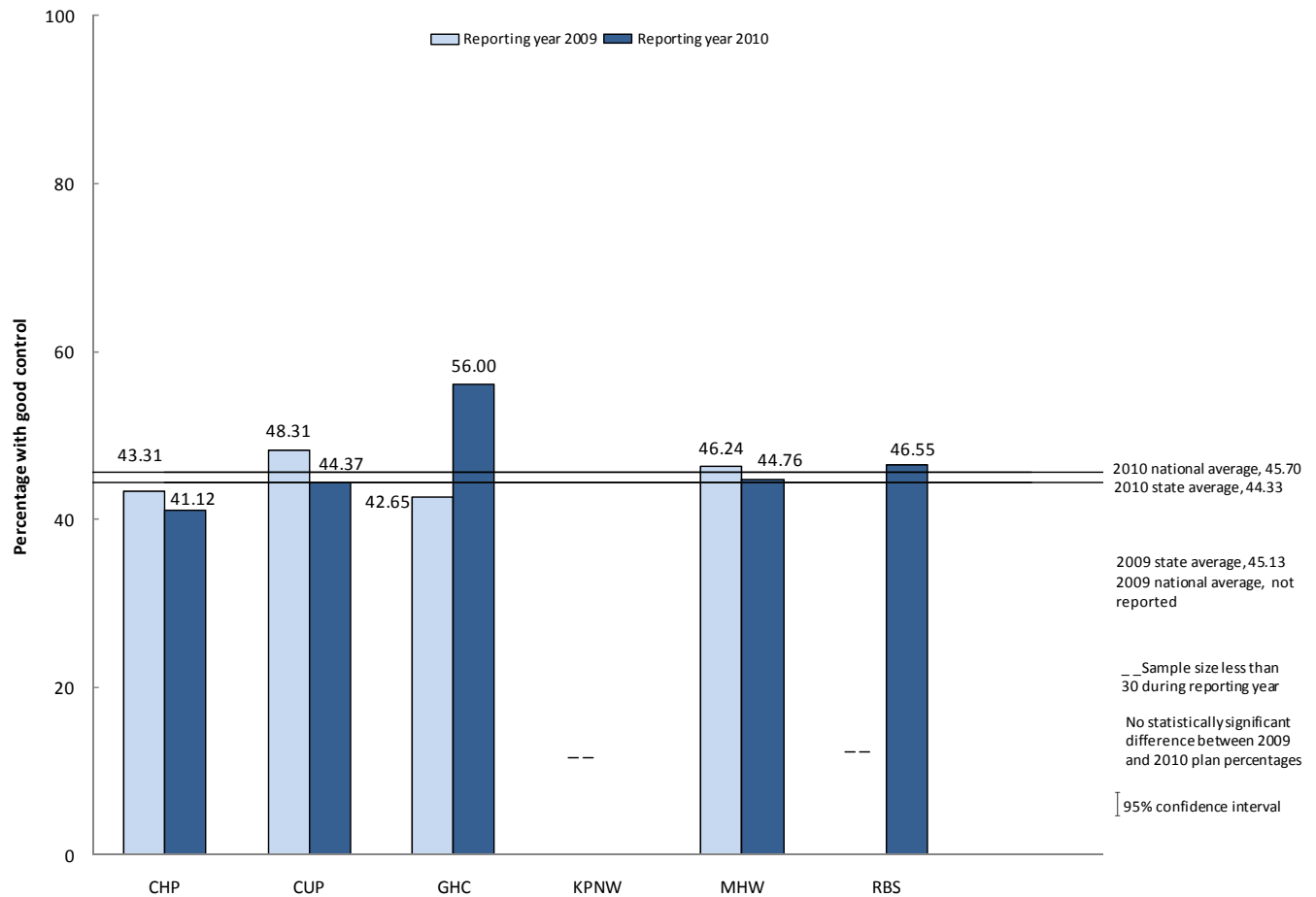


Figure 15. Enrollees with good control of HbA1c levels by health plan, 2009–2010.

Eye exam

The 2010 statewide average for the proportion of Healthy Options enrollees with diabetes who had an eye exam was 58.21 percent; the median was 59.6 percent. Figure 16 shows that all Healthy Options plans surpassed the 2010 national average of 52.65 percent, with the statewide average being significantly higher than the national average.

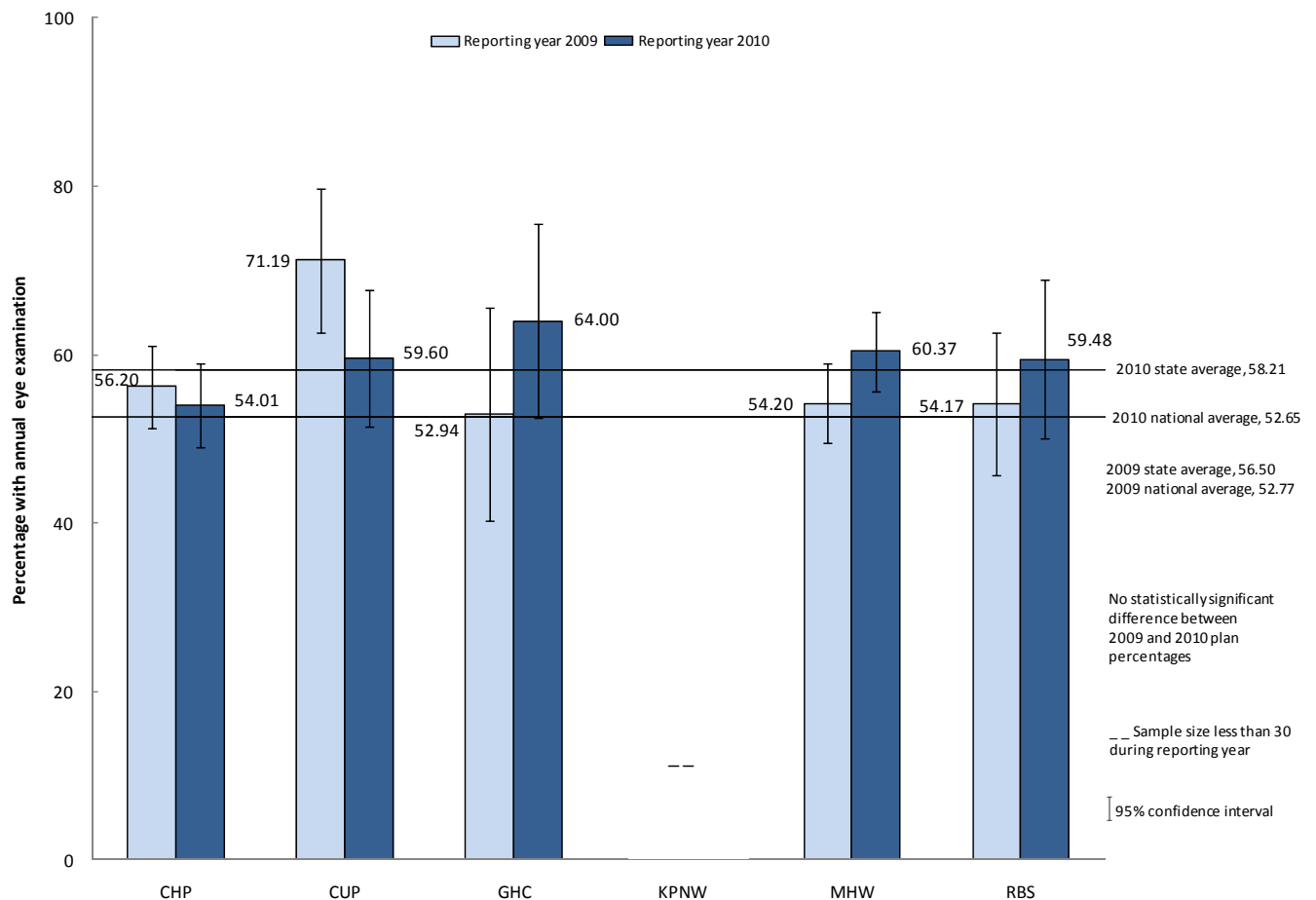


Figure 16. Dilated retinal exams by health plan, reporting years 2009–2010.

Poor glycemic management and longer duration of diabetes lead to increased rates of diabetic retinopathy (DR), which can result in vision loss and blindness. According to the National Institutes of Health (NIH), management of blood sugar, lipid levels, and blood pressure reduces the risks of DR. The Diabetes Control and Complications Trial showed that intensive control of blood glucose dramatically delayed or prevented DR and other complications in people with Type 1 diabetes. Another trial showed that lowering blood glucose and blood pressure levels in people with Type 2 diabetes reduced the risk of DR and other diabetes complications.²⁴

LDL-C screening

The 2010 statewide average for the percentage of Healthy Options enrollees who had a lipid profile (LDL-C screening) performed increased slightly to 68.78 percent; the median was 69.83 percent. Figure 17 shows that CUP, GHC, and RBS performed better than the statewide average, but that average was significantly below the 2010 national average of 74.22 percent.

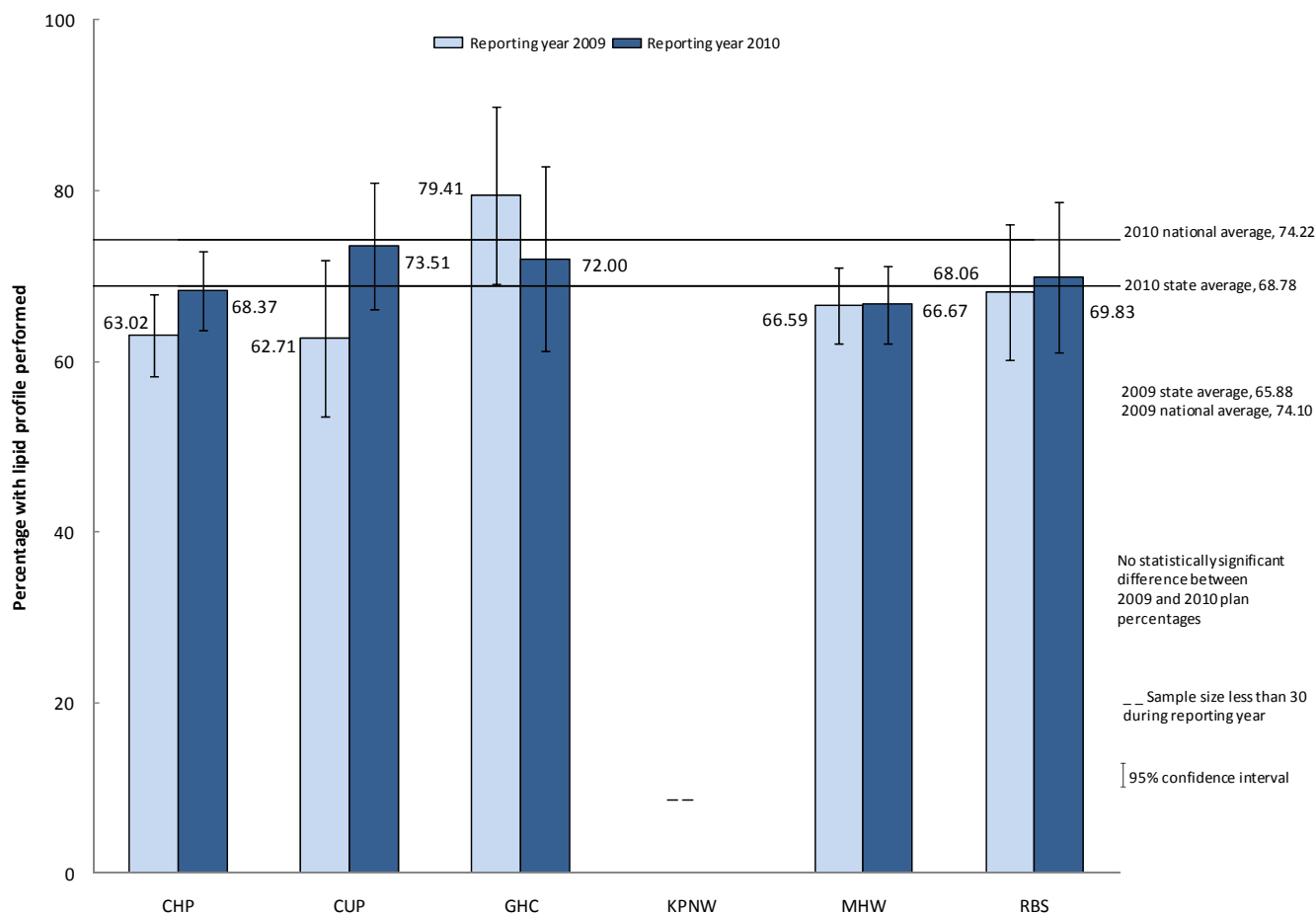


Figure 17. Lipid profile (LDL-C screening) performed by health plan, reporting years 2009–2010.

LDL can deposit excess cholesterol in the walls of blood vessels, contributing to atherosclerosis (hardening of the arteries) and heart disease. People with Type 2 diabetes and high LDL cholesterol have a higher risk for getting cardiovascular disease, the leading cause of death for patients with diabetes.

LDL-C level <100 mg/dL

The 2010 statewide average for the proportion of enrollees with LDL-C levels below 100 mg/dL was 23.86 percent; the median was 22.41 percent. Figure 18 shows that CUP and MHW performed better than the statewide average, which remained significantly below the national average of 33.55 percent. Among all plans, only CUP increased its rate from 2009.

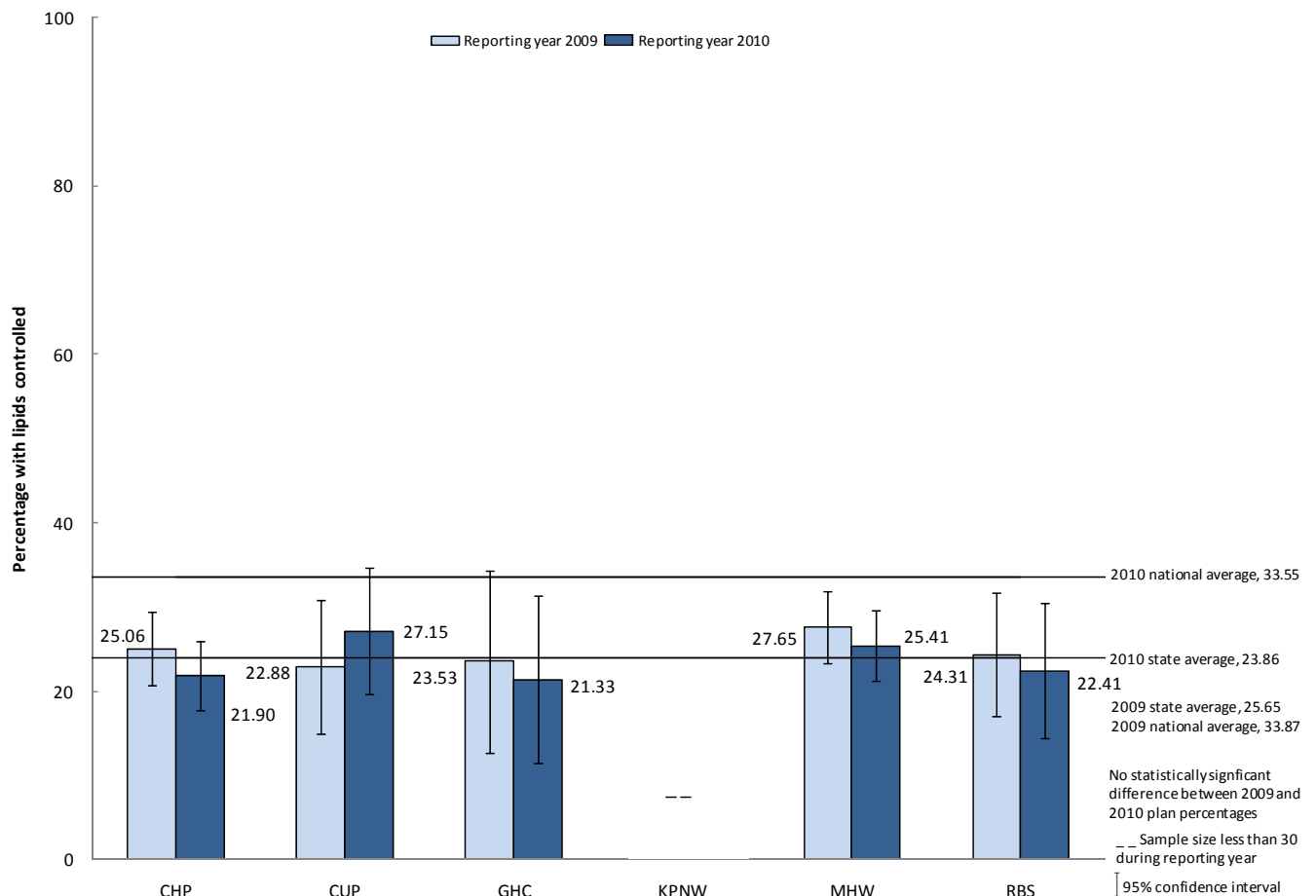


Figure 18. Lipids controlled (<100mg/dL) by health plan, reporting years 2009–2010.

The ADA and the American Heart Association guidelines have recommended since 2001 that patients with diabetes who are at risk for cardiovascular disease maintain lipid levels below 100 mg/dL.^{25,26}

Monitoring for diabetic nephropathy

The 2010 statewide average proportion of enrollees monitored for nephropathy was 72.42 percent, up from 68.82 percent in 2009; the median in 2010 was 73.66 percent. As shown in Figure 19, MHW's performance improved significantly from 2009. RBS's rate was significantly below the statewide average, which, in turn, was significantly lower than the 2010 national average of 76.93 percent.

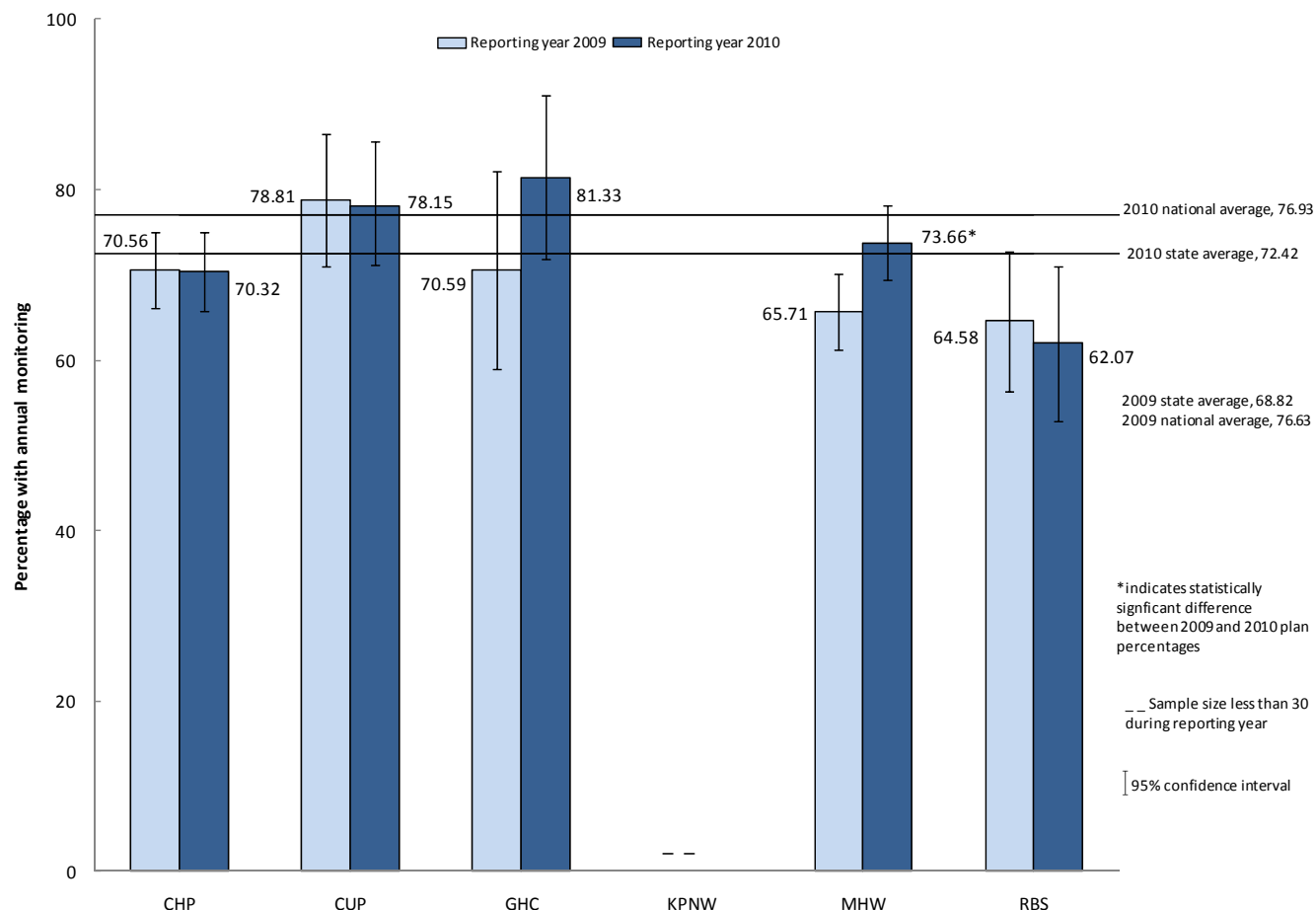


Figure 19. Nephropathy monitored annually by health plan, reporting years 2009–2010.

Diabetic nephropathy is a progressive disease that can cause kidney failure. Diabetes is the most common cause of kidney failure, which must be treated by dialysis or a kidney transplant. In 2007, according to NIH, diabetes caused more than 180,000 cases of kidney failure, at a health care cost of almost \$32 billion.²⁷ About 20 to 30 percent of patients with diabetes develop evidence of nephropathy, although those with Type 2 diabetes are less likely to develop end-stage renal disease.²⁸

Blood pressure control (<140/90 mm Hg)

The 2010 statewide average proportion of enrollees with diabetes whose blood pressure was controlled below 140/90 mm Hg was 69.97 percent, slightly above the 2009 average; the median in 2010 was 69.93 percent. Figure 20 shows that GHC's rate increased significantly from 2009. The 2010 statewide average was significantly above the national average of 59.76 percent, and all Healthy Options plans performed well above the national average.

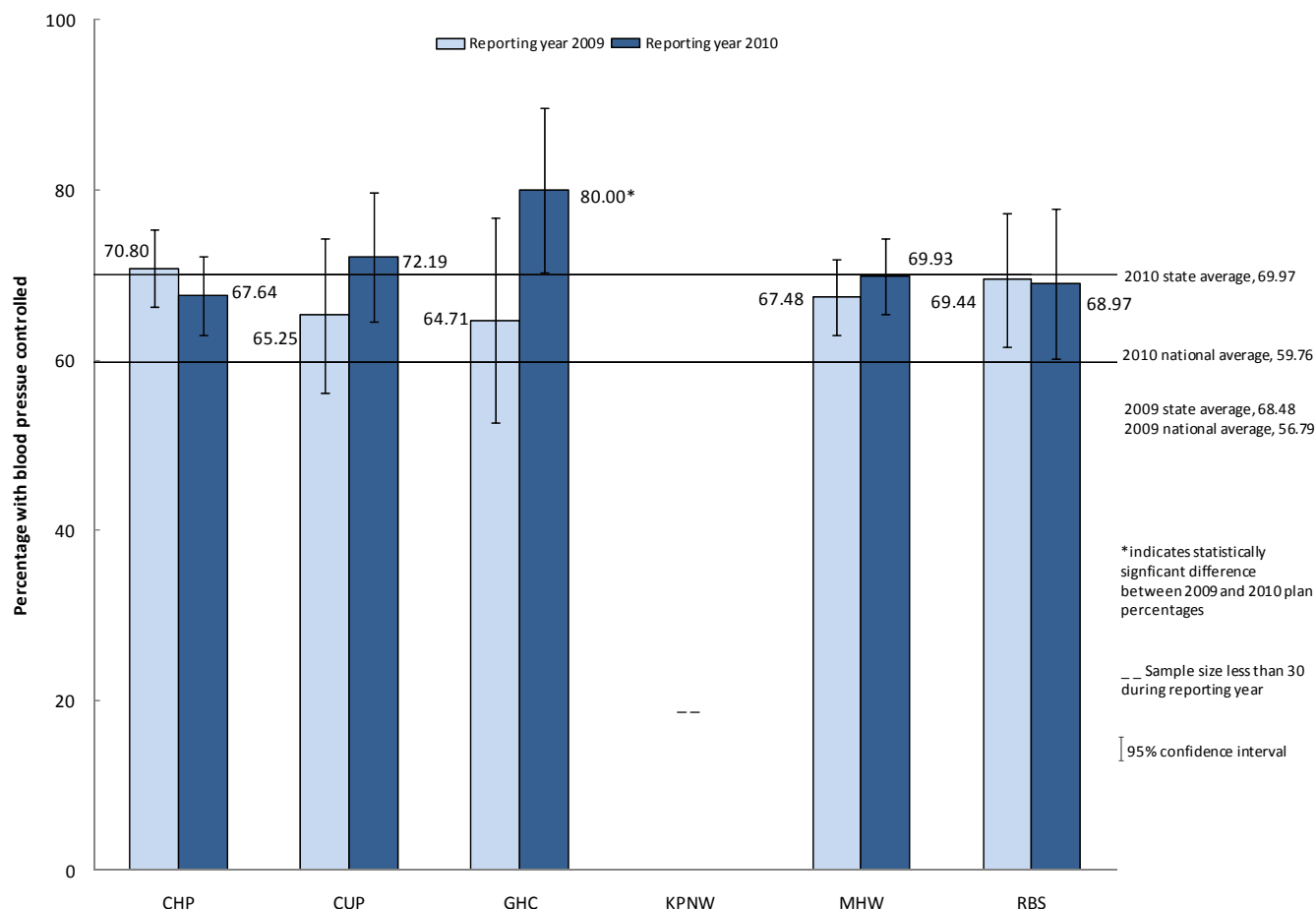


Figure 20. Blood pressure controlled (<140/90 mm Hg) by health plan, reporting years 2009–2010.

High blood pressure is a significant risk factor for developing many complications of diabetes, such as nephropathy and retinopathy. Each reduction of 10 millimeters of mercury in systolic blood pressure reduces the risk of diabetic complications by 12 percent.²⁹

Blood pressure control (<130/80 mm Hg)

The 2010 statewide average proportion of enrollees with diabetes whose blood pressure was controlled below 130/80 mm Hg was 38.24 percent; the median was 38.79 percent. Figure 21 shows that between 34 and 47 percent of enrollees in Healthy Options plans have their blood pressure controlled below this level. The 2010 state average was significantly above the national average of 32.22 percent, and all Healthy Options plans outperformed the national average.

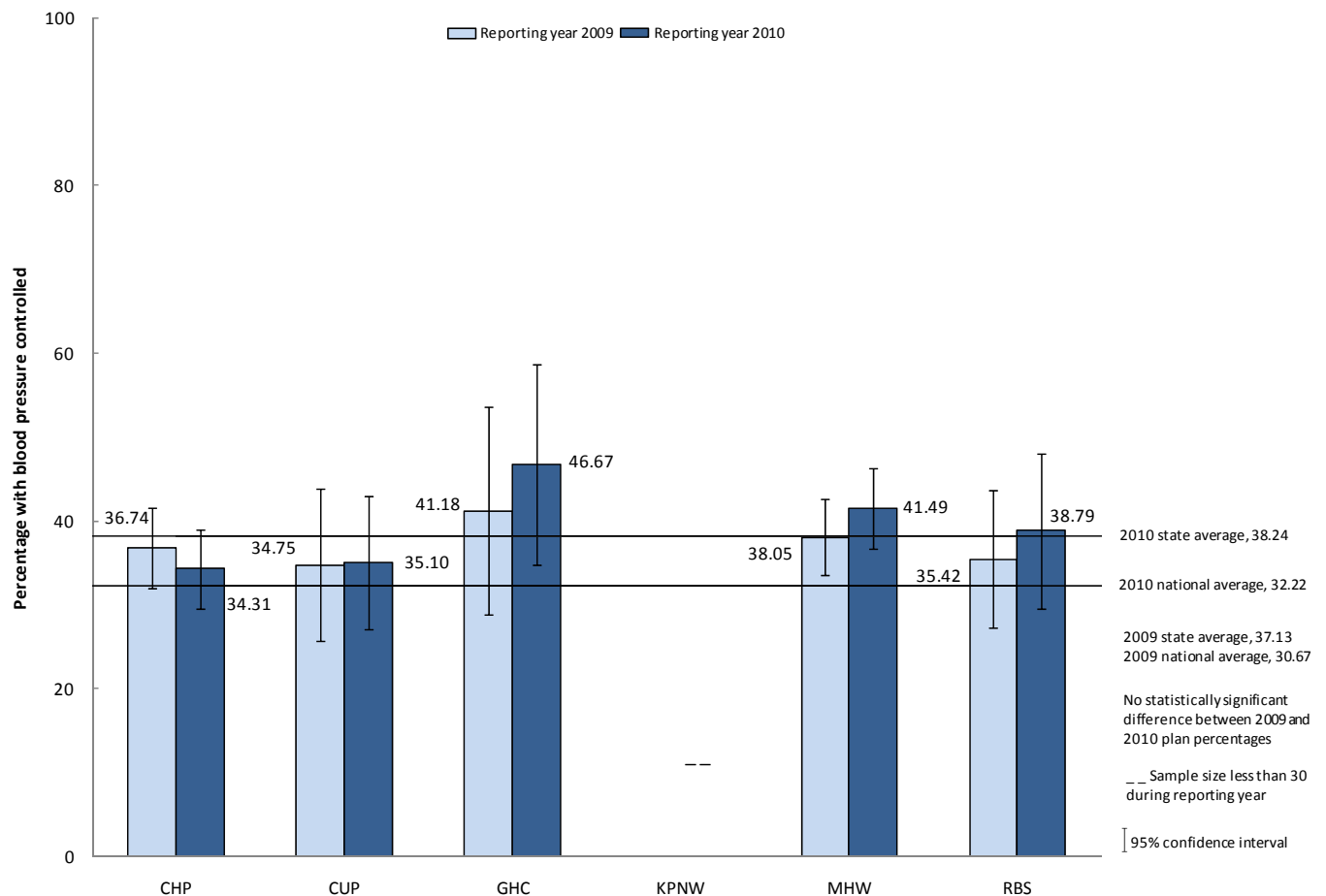


Figure 21. Blood pressure controlled (<130/80 mm Hg) by health plan, reporting years 2009–2010.

The American Diabetes Association and the National Heart, Lung, and Blood Institute recommend that people with diabetes maintain a blood pressure of less than 130/80 mm Hg.

Discussion and recommendations

On the whole, the Healthy Options plans continued to improve their performance on the majority of diabetes care indicators in 2010; exceptions were the indicators for poor HbA1c control and LDL-C levels. As a group, the plans continue to outperform the national Medicaid average for HbA1c testing and control, dilated retinal exams, and the two blood-pressure control indicators. This trend, consistent with previous years' results, will continue to have a positive impact on Healthy Options enrollees. Still, the absolute performance levels leave room for improvement in most indicators.

Successful interventions to reduce the onset and improve management of diabetes would save lives and reduce costs for Washingtonians. Acumentra Health recommends that the Healthy Options plans develop care coordination and disease management programs, partnering with providers to implement a proactive approach to diabetes care. The Chronic Care Model (CCM) is a proven model, both nationally and locally, and all plans have received training in this method. Key steps in the CCM include

- identify the population with diabetes
- follow evidence-based guidelines
- provide case management for the high-risk population
- partner with community organizations to combine resources for people with diabetes
- engage patients in self-management and care

In addition, Acumentra Health recommends that the health plans

- partner to create uniform practice guidelines for providers, similar to those for asthma
- provide financial support and training for clinics to implement the Chronic Disease Electronic Management System (CDEMS) and/or an electronic health record
- continue efforts to improve administrative data completeness, and consider creating a case management registry to improve access to relevant data (e.g., laboratory screening and results, most recent blood-pressure results, and pharmacy data)
- encourage use of educational materials from the federal government—for example, the National Diabetes Education Program's "Control Your Diabetes. For Life" campaign³⁰

The health plans also should examine other models of effective diabetes care management. For example, Arkansas' Department of Health and Human Services implemented the Diabetes Disease Management Program, honored by the Utilization Review Accreditation Commission's (URAC) 2009 Best Practices in Health Care Consumer Empowerment and Protection Awards. As part of this program, Medicaid clients receive intensive self-management education from a qualified educator at one of many diabetes education centers throughout the state. Topics include self-examination of the eyes, feet, and skin; making healthy food choices; the importance of exercise; and blood glucose monitoring.

Postpartum Care

Making certain that pregnant women receive prenatal and postpartum care is essential to ensure that babies are born healthy and remain healthy. In particular, timely postpartum care can help providers detect early signs of problems in the baby's or mother's health.

The American College of Obstetrics and Gynecology strongly encourages pregnant women to schedule an OB/GYN appointment before the 12th week of pregnancy and within 4–7 weeks after the baby's birth.³¹ The HEDIS specifications for this measure align with those time frames. Since 2008, MPA no longer requires the Healthy Options plans to report rates for delivering prenatal care.

Measure definition

This measure combines timely initiation of prenatal care with a postpartum visit for female enrollees who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year. Enrollees had to be continuously enrolled at least 43 days prior to delivery and 56 days after delivery. For these women, the measure assesses

- postpartum care: percentage who had a postpartum visit on or between 21 days and 56 days following delivery

Data collection method: Administrative or hybrid

The percentage of Healthy Options enrollees receiving timely postpartum care has remained stable in the low-60 percent range since 2004. The statewide average had remained consistently above the national average until this year, when it dipped slightly below the national average of 64.08 percent.

The 2010 state average for delivery of timely postpartum care was 62.82 percent, nearly the same as in 2009; the median in 2010 was 61.85 percent. Figure 22 shows that GHC's and RBS's averages exceeded the national average in 2010, while GHC's average once again significantly exceeded the state average.

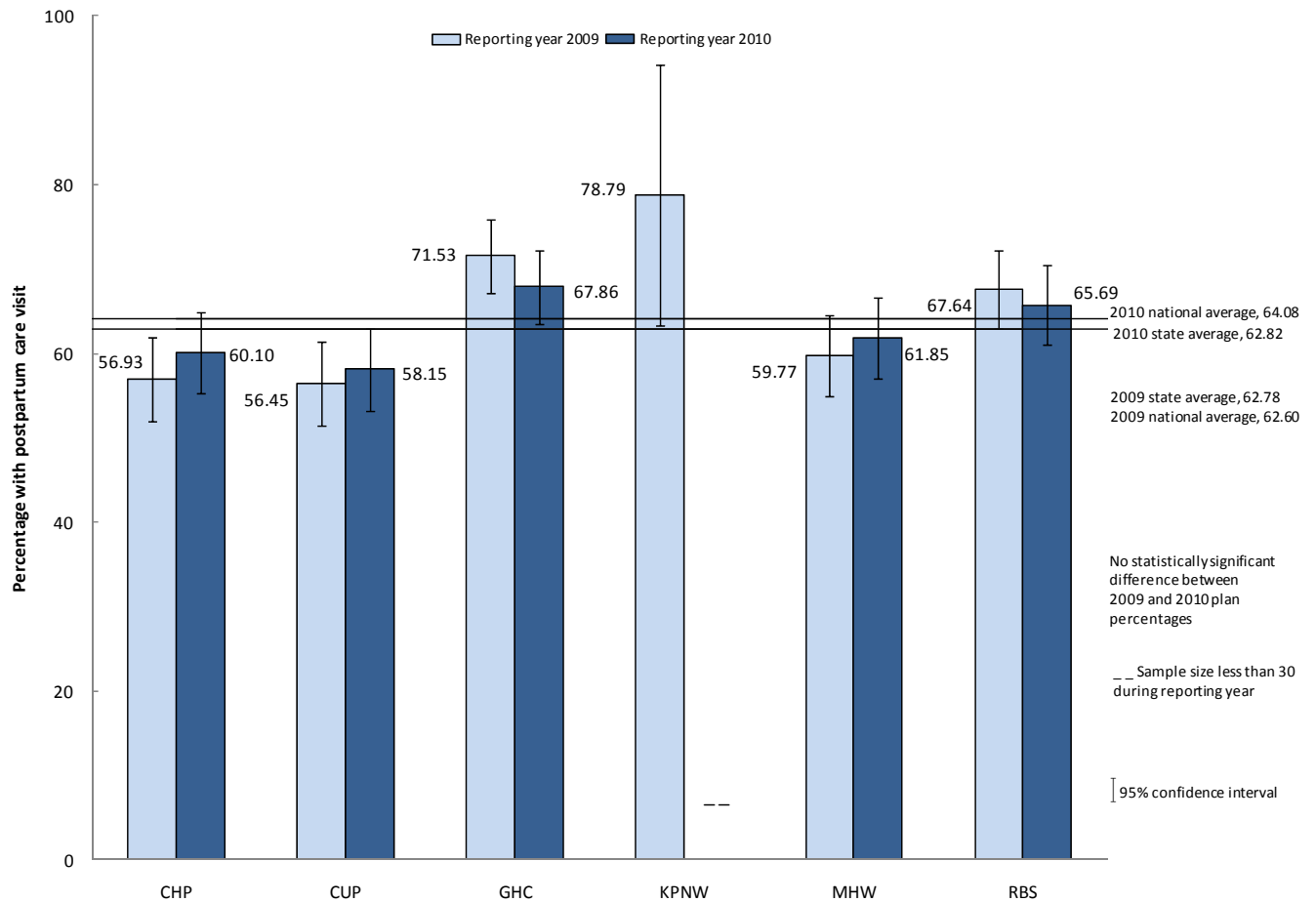


Figure 22. Postpartum care visits by health plan, reporting years 2009–2010.

Discussion

The statewide performance on this measure has remained static for the past five years, while the national average has increased by more than 7 percentage points. However, the 2010 Washington average of 62.82 percent is slightly above the Pacific Region's rate of 62.63 percent. The East North Central Region reported the highest rate for this measure at 87.17 percent; the lowest rate, 57.36 percent, was in the Mountain Region.

As noted in previous reports, the HEDIS specifications pose challenges to health plans in capturing accurate data for this measure. The time frame for counting women in the numerator may result in underreporting the number of women who actually receive this care.

While care strategies tend to emphasize the prenatal period, appropriate care during the postpartum period can also prevent complications and deaths. Some women experience emotional instability during the postpartum period that may warrant a follow-up visit with their healthcare provider. Women also may benefit from personalized care during this time to enhance the development of a healthy mother-infant relationship.

Recommendations

Acumentra Health's previous recommendations still apply. MPA may wish to consider using an alternate methodology to measure postpartum care, such as a focused performance improvement study. Such a study might provide insight into the lack of change in performance on this measure, by ascertaining whether care is or is not received and whether care is received but not within the time frame for the HEDIS measure.

Healthy Options plans may also wish to monitor their utilization data to identify female enrollees who are not receiving postpartum care, within or outside of the HEDIS time frame. Those not receiving care may be a target population for PIPs designed to provide patient education and to use outreach methods to encourage appointments for care.

Well-Child Care Visits

Professional healthcare organizations recommend that children and adolescents visit the doctor regularly for screening and examinations to support healthy growth and development, as well as for counseling on nutrition and other topics. The American Academy of Pediatrics and the American Medical Association recommend comprehensive annual checkups for adolescents to address risk conditions and behaviors, such as obesity, sexually transmitted diseases, substance abuse, and tobacco use.³² Health plans focus their efforts on outreach to families regarding the availability and benefits of WCC through Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program. The HEDIS measures evaluate the success of health plans in providing these services by assessing the percentage of Medicaid children in each plan with the recommended number of visits for each age group.

Measure definitions

HEDIS measures evaluate the success of health plans in providing well-child services by assessing the percentage of Medicaid children with the recommended number of

- well-child visits in the first 15 months of life: the percentage of enrolled children who turned 15 months old during the measurement year, were continuously enrolled in the plan from 31 days and received between zero and six or more well-child visits with a PCP in their first 15 months of life
- well-child visits in the 3rd, 4th, 5th, and 6th years of life: the percentage of enrolled children who were between three and six years old during the measurement year, were continuously enrolled for 12 months, and received one or more well-child visits with a PCP during the measurement year
- adolescent well-care visits: the percentage of enrolled adolescents ages 12–21 years during the measurement year who were continuously enrolled for 12 months and had at least one comprehensive well-care visit with a PCP or an obstetrics/gynecology practitioner during the measurement year

Data collection method: Administrative or hybrid

Since 2002, MPA has collaborated with health plans on interventions aimed at increasing WCC visit rates for children in Healthy Options. MPA required the health plans to participate in the Washington State Collaborative to Improve Health (WSC), which concluded in May 2009. This group learning project, funded primarily by MPA and DOH, was part of a multi-year effort to improve health care for Washingtonians with chronic diseases, including preventive care and the establishment of a medical home for children.

Clinics participating in the WSC reported increased WCC visits, with particularly strong gains in providing planned chronic care management visits for children. Overall, the WSC demonstrated that clinics can accomplish substantial improvements in both the quality and effectiveness of preventive and chronic care services delivered to Medicaid children.

MPA requires plans to formulate corrective action plans when performance on the WCC measure falls below a certain level.

Five-year trends in WCC visits

Figure 23 shows trends for the state averages in WCC visits for infants (six or more visits), children (one visit), and adolescents (one visit). As a group, the Healthy Options plans showed a modest gain in the rate of child WCC visits in 2010, to 62 percent, while the adolescent WCC visit rate remained at 37 percent and the infant WCC visit rate fell significantly, from 57 percent to 52 percent. The statewide averages for all three indicators remain significantly below the national averages.

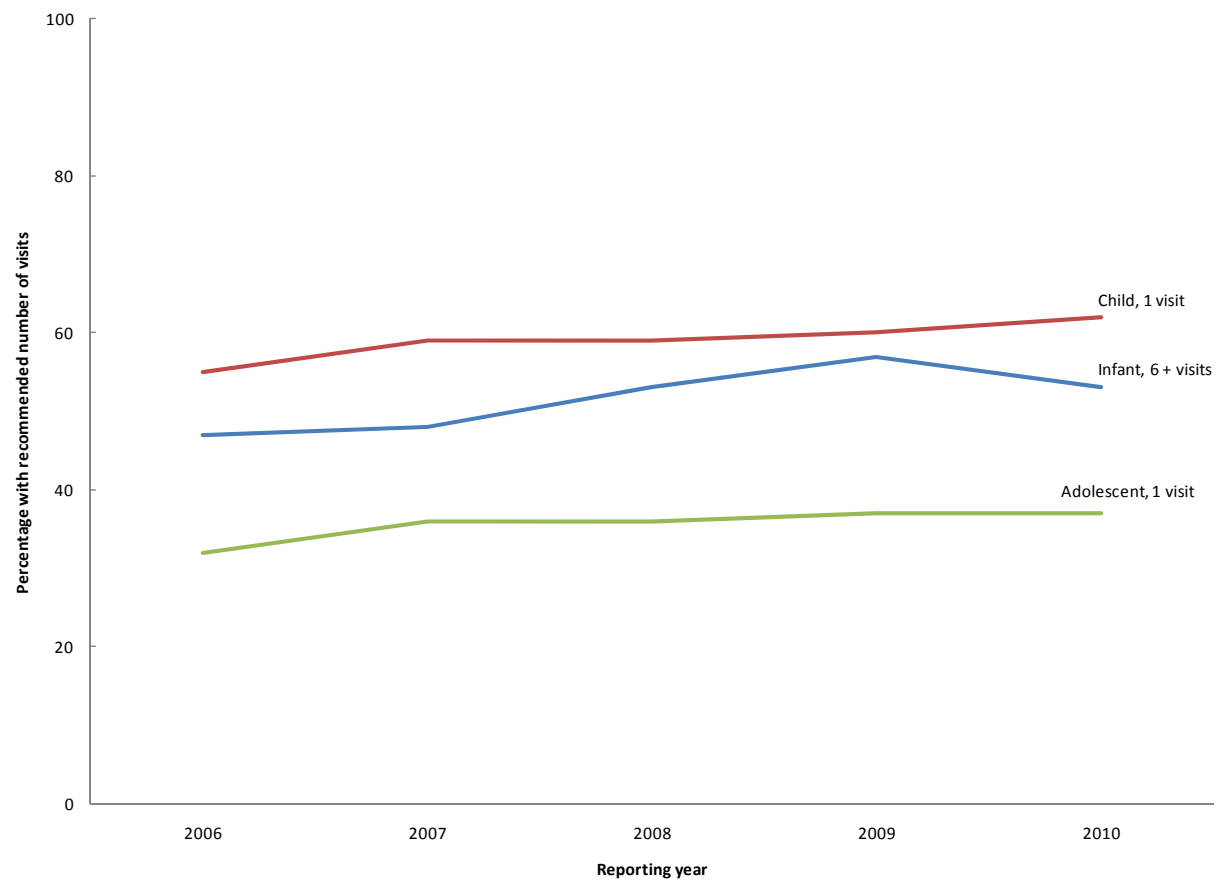


Figure 23. State averages for recommended WCC visits for infants, children, and adolescents, reporting years 2006–2010.

Well-child care in the first 15 months of life

The 2010 statewide average for infants in the first 15 months of life who received six or more WCC visits was 52.57 percent, down significantly from 57.05 percent in 2009; the median in 2010 was 50.85 percent. MHW significantly outperformed the Healthy Options average. CUP's rate (50.85 percent) fell significantly from the previous year. Figure 24 shows that the statewide average in 2010 was significantly below the NCQA average of 59.30 percent.

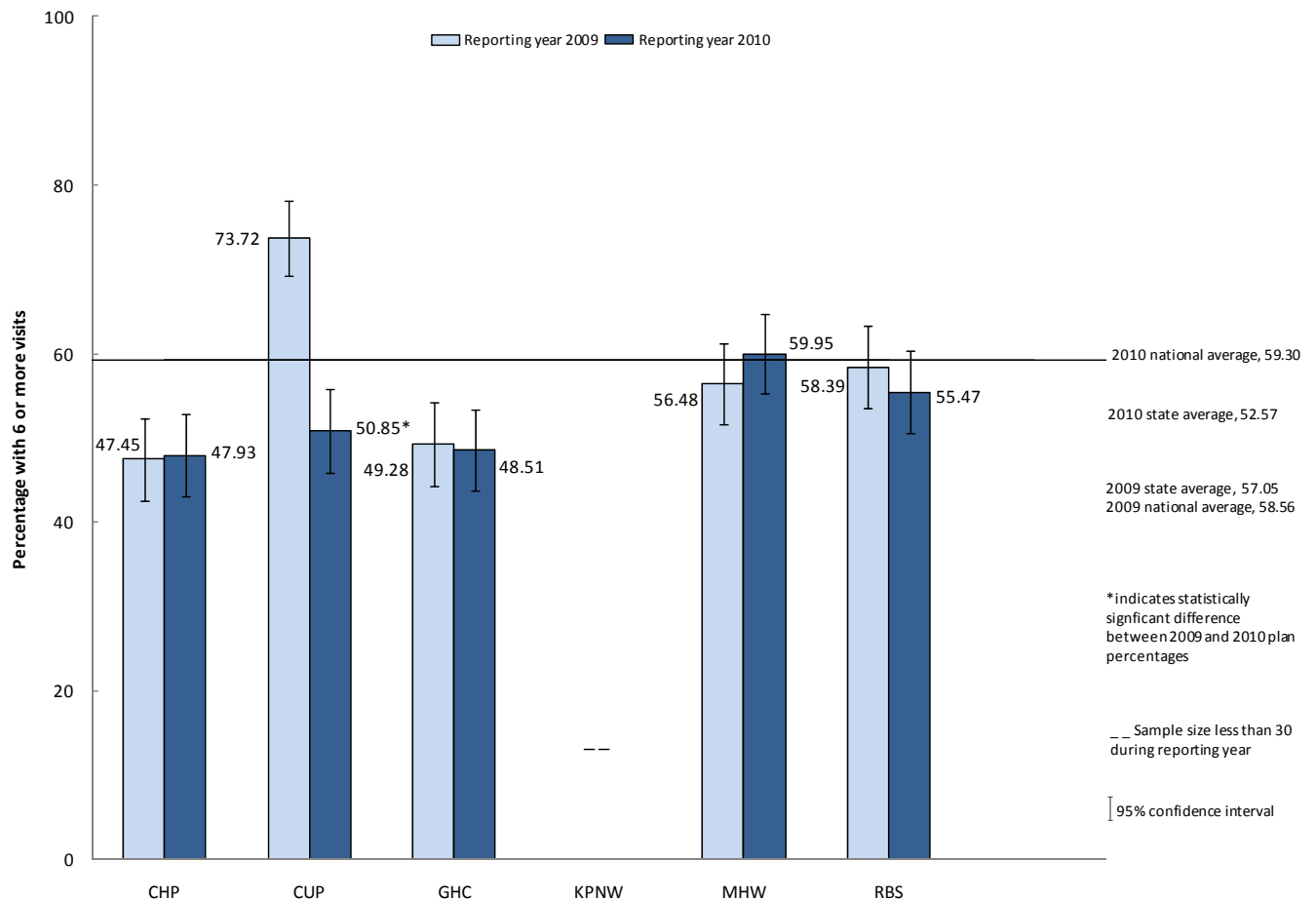


Figure 24. Six or more well-child visits in the first 15 months of life by health plan, reporting years 2009–2010.

The 2010 statewide average for infants receiving *five* WCC visits was 21.36 percent; the median was 21.41 percent. Figure 25 shows that CUP's and GHC's rates increased significantly from the previous year. The 2010 statewide average for this indicator was significantly above the national average of 16.45 percent.

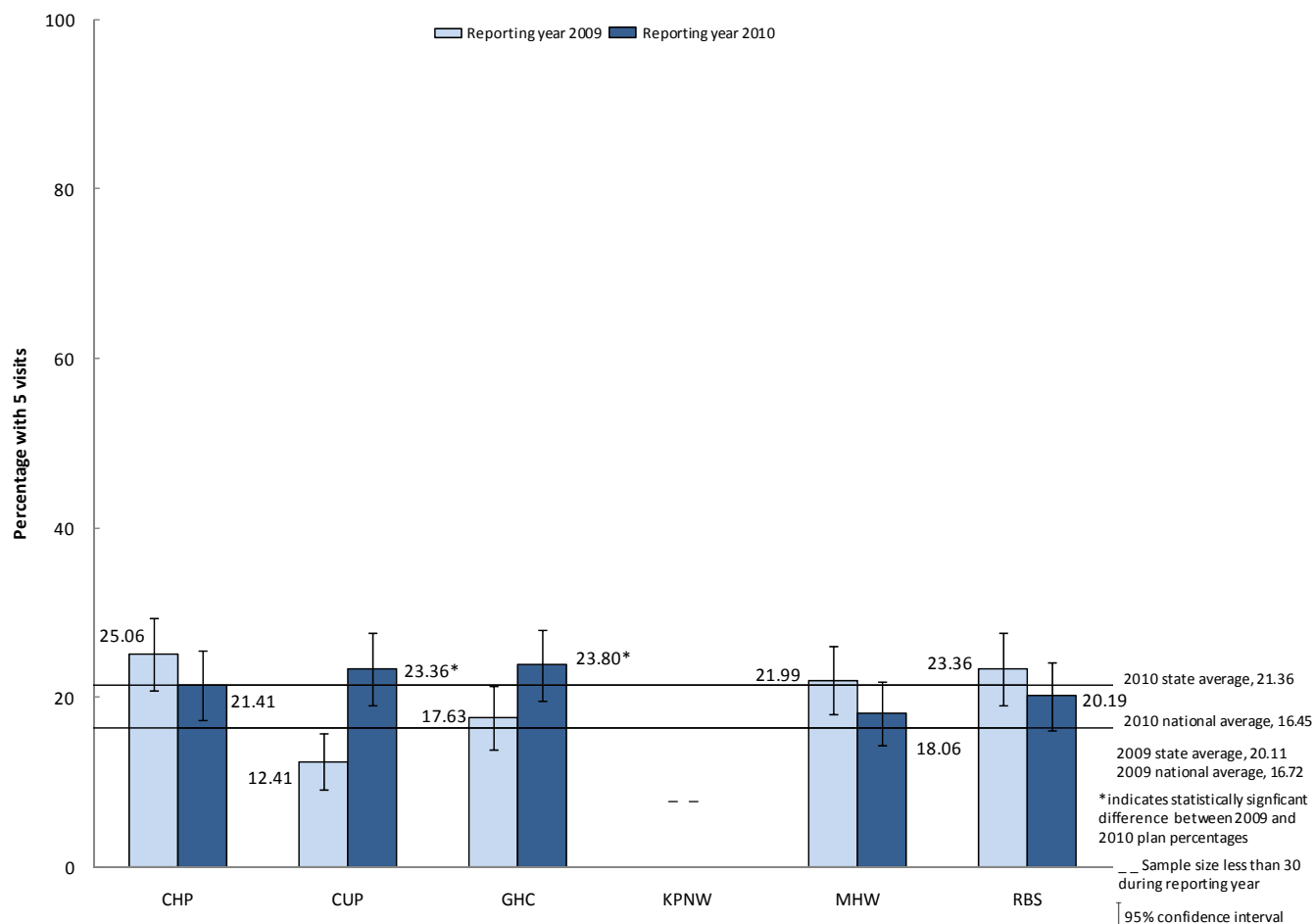


Figure 25. Five well-child visits in the first 15 months of life by health plan, reporting years 2009–2010.

Table 3 shows the percentages of enrollees who received *no* infant WCC visits during the measurement year. Lower percentages for this indicator are desirable—fewer infants with no visits means that almost all infants received at least one WCC visit during the year. The 2010 statewide average was well below the 2009 average, and was significantly lower (i.e., better) than the 2010 NCQA average of 2.31 percent.

Table 3. Percentage of infants who received zero well-child visits, reporting year 2010.

	CHP	CUP	GHC	KPNW	MHW	RBS	State	NCQA
%	0.97	0.73	0.69	—	0.46	0.24	0.62	2.31
n	411	411	437	—	432	411	2,102	*

— Sample size was less than 30 during the reporting year.

*Approximately 150 plans submitted data to NCQA; however, the actual sample size is unknown.

Well-child care for children in the 3rd, 4th, 5th, and 6th years of life

The 2010 rate of WCC visits for children in this age group was 62.15 percent across the Healthy Options plans, slightly higher than the 2009 average of 59.91 percent; the median in 2010 was 62.53 percent. The statewide average has improved significantly since 2006, up from 55 percent, yet it remained significantly below the national average of 71.62 percent in 2010. Figure 26 shows that KPNW and CUP significantly improved their visit rates in 2010. Both KPNW and MHW significantly outperformed the statewide average, while ANH's rate was significantly below average.

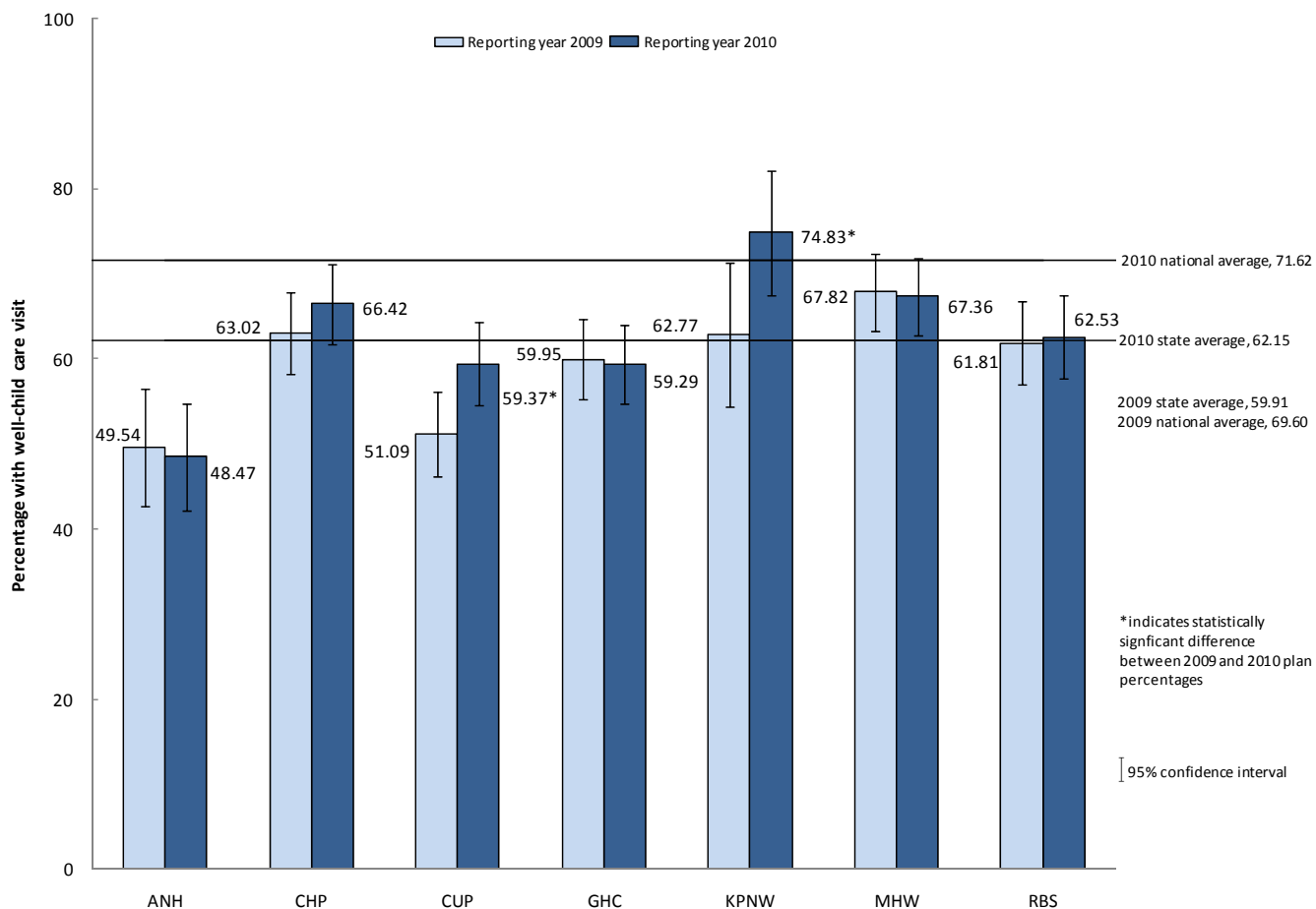


Figure 26. Well-child visits in the 3rd, 4th, 5th, and 6th years of life by health plan, reporting years 2009–2010.

Adolescent well-child care

The 2010 statewide average performance for WCC visits for adolescents ages 12–21 was 36.62 percent, slightly below the 2009 average; the median in 2010 was 37.39 percent. Figure 27 shows that the Healthy Options plan results were mixed in 2010, with MHW's rate declining significantly. The statewide average remained significantly below the 2010 national average of 47.64 percent.

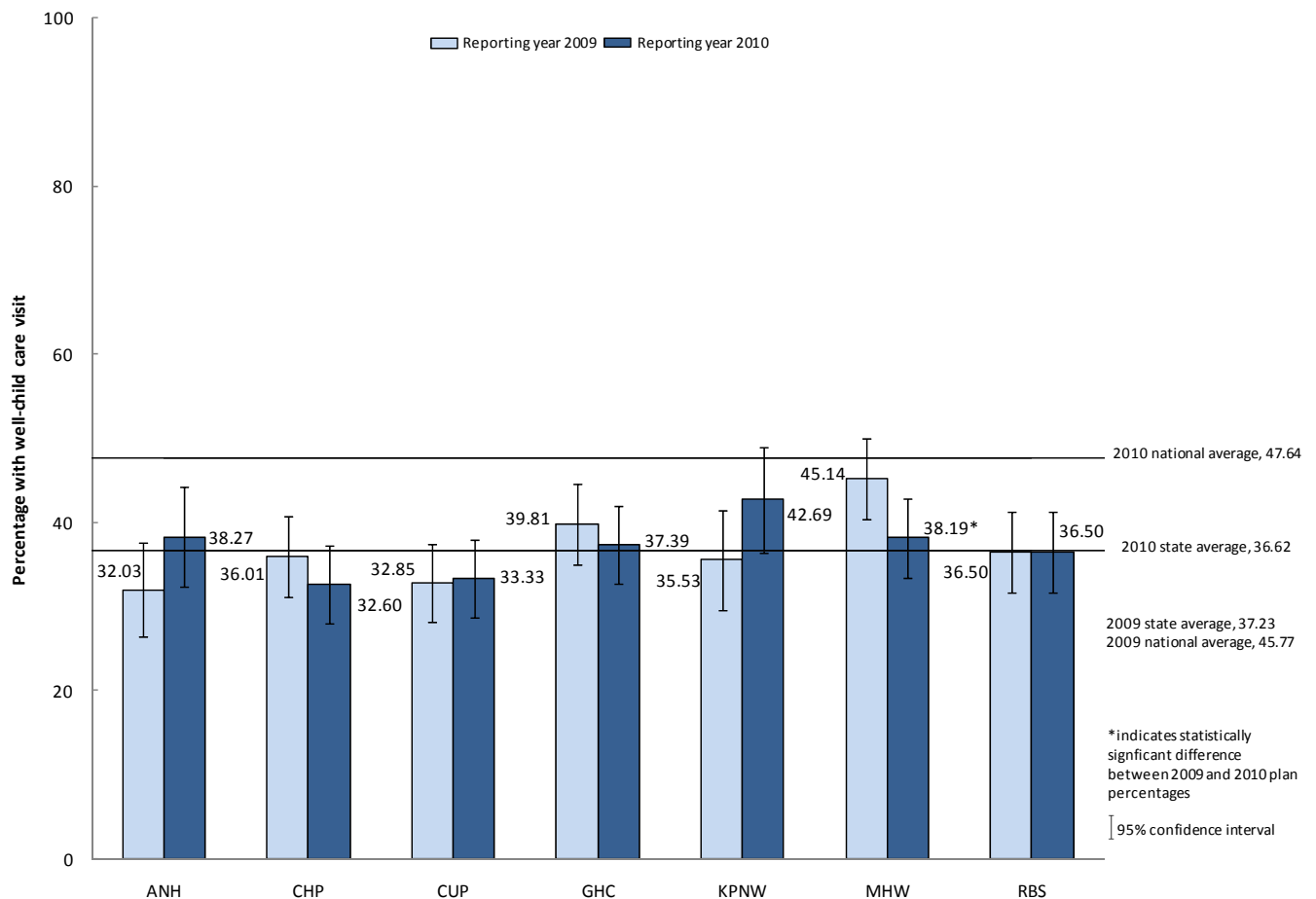


Figure 27. Adolescents ages 12–21 with one or more well-care visits by health plan, reporting years 2009–2010.

Member-level data analysis

MPA required the Healthy Options plans to submit de-identified member-level data on WCC visits for the first time in 2010. Acentra Health received enough data to analyze and report differences in performance by DSHS region, gender, primary language, and race/ethnicity.

Region	Counties
1	Adams, Asotin, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Whitman
2	Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima
3	Island, San Juan, Skagit, Snohomish, Whatcom
4	King
5	Kitsap, Pierce
6	Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, Wahkiakum

- **Rates by region:**
 - *Infants:* Region 3's WCC visit rate of 60.54 percent was significantly higher than the combined rate of all other regions; Region 1's rate of 41.01 percent was significantly lower than all other regions.
 - *Children:* Region 4 significantly outperformed all other regions at 72.11 percent; Region 1 was significantly lower than all other regions at 56.25 percent.
 - *Adolescents:* Region 4's rate of 39.77 percent was significantly higher than all other regions; Region 2's rate of 30.39 percent was significantly below all other regions.
- **Rates by gender:**
 - No significant differences by gender were identified among the regions.
- **Rates by primary language:**
 - Spanish-speaking enrollees in the child and adolescent age groups received WCC visits at significantly higher rates compared with Russian and English speakers. More than 75 percent of Spanish-speaking children received a WCC visit.
 - Among children and adolescents, Russian-speaking enrollees received WCC visits at significantly lower rates compared with English and Spanish speakers.
- **Rates by race/ethnicity:**
 - Hispanic children and adolescents had higher WCC visit rates than non-Hispanic enrollees in those age groups—significantly higher for Hispanic adolescents.
 - Asian infants and children had the highest WCC rates in those age groups, although not significantly higher than others.
 - Among adolescents, African-American enrollees had significantly higher WCC visit rates than other groups.

- **Rates by urban/rural:**

- Urban dwellers had significantly higher WCC visit rates for infants and children than did rural dwellers—significantly higher for the infant group.
- Adolescents living in rural areas received WCC visits at a slightly higher rate than those living in urban areas, though not significantly higher.

Discussion

The Healthy Options plans continue to lag behind the national Medicaid performance in providing WCC visits—significantly below the national averages for children and adolescents. The long-term improvement in WCC visit rates for infants and children is encouraging, despite the sharp decline in the infant visit rate in 2010. The average number of Healthy Options infants receiving *at least five* WCC visits significantly exceeds the national average, and almost 99 percent of infants are receiving at least one WCC visit in the first 15 months of life. Still, on average, almost half of the infants and children and two-thirds of the adolescents served by the plans are *not* receiving care at the recommended levels. Providing WCC visits for adolescents remains a particular challenge due to barriers noted in our previous reports.

As reported in the 2010 NCQA *Quality Compass*, WCC visit rates for the Pacific Region (Alaska, Washington, Oregon, California, and Hawaii) fell below the top-performing region. The New England Region outperformed other regions for all three age groups, reporting rates of 73.72 percent for infants, 80.01 percent for children, and 61.50 percent for adolescents, compared with the Pacific Region's 51.60 percent for infants, 71.53 percent for children, and 40.70 percent for adolescents. The Pacific Region reported the nation's lowest WCC visit rates for infants and adolescents.

Within Washington, member-level data analysis shows that the highest WCC visit rates occurred in King County (Region 4) for children and adolescents, and in Region 3, north of Seattle, for infants. The lowest WCC visit rates occurred east of the Cascades (Regions 1 and 2). With respect to primary language, WCC visit rates for children and adolescents were highest for Spanish speakers and lowest for Russian speakers. For the same age groups, Hispanic enrollees received visits at higher rates than non-Hispanic enrollees. Among adolescents, African-American enrollees had significantly higher WCC visit rates than other groups. Results by urban/rural residence were mixed, depending on age group.

For 2010, all Healthy Options plans conducted PIPs aimed at improving WCC visit rates, as required by contract. TEAMonitor, the interagency entity responsible for evaluating the PIPs, cited as a best practice CHP's Quality Grant Program to support providers in developing interventions. All 19 community health centers have developed interventions to increase WCC visit rates, and CHP supports the interventions with quarterly reports, incentives, and technical assistance. Other best practices include physician leadership for GHC's PIP, as well as KPNW's interventions with providers, which include a web-based Panel Support Tool and bundled incentives for providers targeting improvement in pediatric WCC measures.

MCOs continue to dedicate significant resources in an effort to capture complete data for all well-child performance measures. Reliance on medical chart data to complete the data collection remains an issue for most MCOs. Chart abstraction is expensive, and the reviewers often face challenges interpreting elements of the well-child exam such as anticipatory guidance. In an effort to reduce the cost of hybrid data collection, some states, like New York, are moving to the

use of administrative-only rates for the well child measures. To support data completeness, the New York Medicaid agency supplies the MCOs with enhancement files containing any fee-for-service preventive health claims paid outside of the plan. MCOs use the claims for HEDIS measures and quality reporting to help enhance their administrative data sets.

Recommendations

Acumentra Health recommends that MPA

- promote collaboration among health plans to implement best practices at a clinic level, such as reminder/recall notices, structured examination tools, and patient-centered care
- address improving adolescent WCC rates through focused training for providers, alternate delivery mechanisms for care, or collaboration with school-based clinics to capture and count preventive care encounters
- reimburse the Healthy Options plans for adolescent WCC visits on an annual basis rather than every other year, in line with the recommended annual screening schedule reflected in the HEDIS criteria
- investigate WCC rates at the county level to identify best practices among top-performing clinics
- expand sports physical exams to include WCC elements for adolescents who are due or overdue for an exam, perhaps providing a sports-related incentive to teens who get their exams
- consider eliminating the requirement for hybrid data collection
- provide MCOs with enhancement files to support HEDIS reporting

Emergency Room Visits

During 2007, one in five Americans visited an emergency room (ER) at least once. Medicaid recipients were more likely than people with private coverage or uninsured people to report multiple ER visits during the year; among Medicaid recipients under age 65, more than one in four children and two in five adults visited the ER at least once, and about 15 percent made two or more visits. One in 10 ER visits by people under age 65 were considered nonurgent, whether the patients had private insurance, Medicaid coverage, or no insurance.³³

Previous studies have indicated that a patient's decision to visit an ER instead of a clinic or a physician's office may result from insufficient access to primary care, due to multiple factors. Access to an urgent care center or to primary care clinics with evening hours may reduce the number of nonurgent ER visits.³⁴ According to the CDC, however, the 2007 data showed that people without a usual source of medical care are *not* more likely to visit the ER than are those with a usual source of care, and uninsured people are *not* more likely than others to visit the ER for nonurgent reasons. The CDC called for future research to focus on "untangling the complex interactions among the sociodemographic, health status, and health care access factors" that appear to be associated with visits to the ER.

In 2010, Healthy Options plan enrollees averaged 59.75 ER visits per 1,000 member months, up significantly from 2009, yet still significantly below the national average of 67.55 visits, as has been the case since 2006 (see Figure 28).

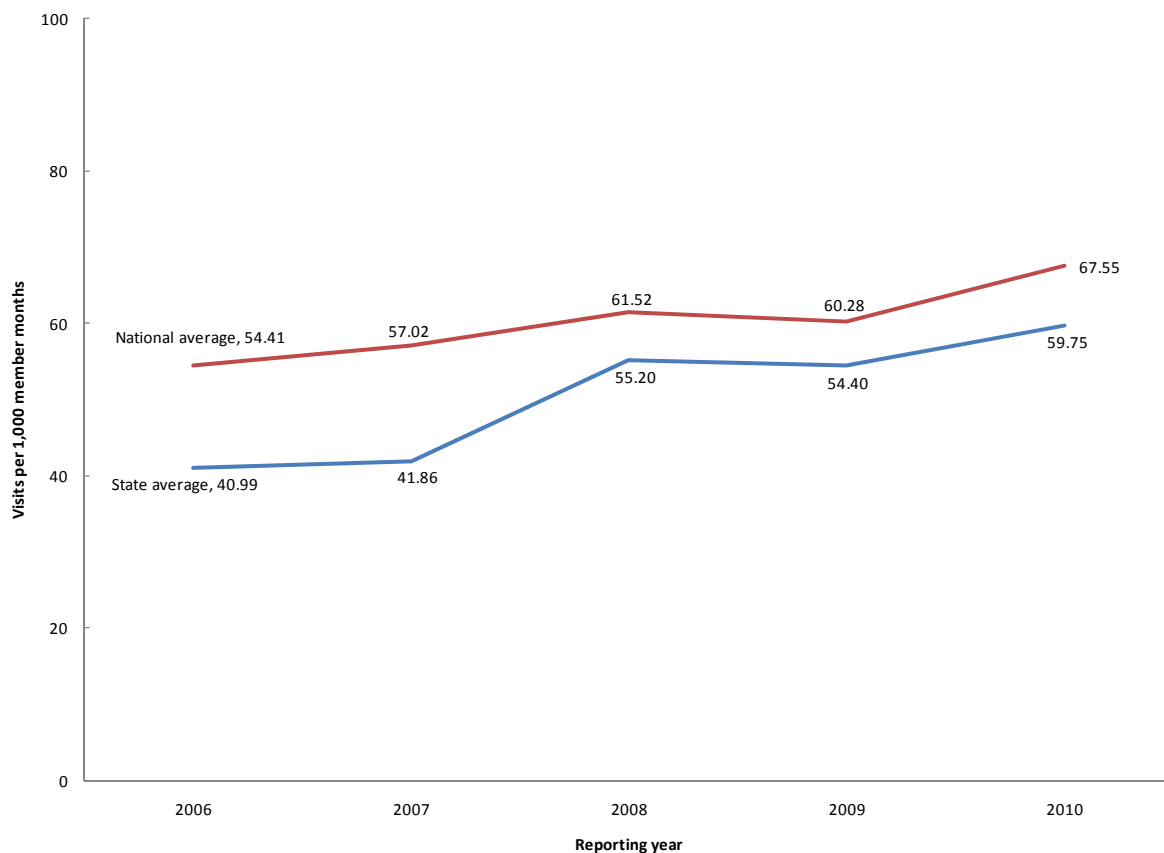


Figure 28. State and national averages for ER utilization, reporting years 2006–2010.

All but two Healthy Options plans (ANH and KPNW) reported significantly higher ER visit rates in 2010 than in 2009. Visit rates among plans vary widely, ranging from 13.66 (KPNW) to 76.21 (RBS) visits per 1000 member months. (See Appendix B).

MPA attributes the state's below-average ER utilization rates to a strong system of community health clinics (CHCs) and relatively high penetration of Medicaid managed care. In an effort to reduce inappropriate ER use, MPA sought and received funding from the Centers for Medicare & Medicaid Services (CMS) to establish CHCs as alternate nonemergency service providers for 50,000 Medicaid beneficiaries. Four partnership/collaboratives received about \$200,000 a year for two years to implement ER diversion programs. Each initiative involves a contracted clinic or hospital working in collaboration with a partner hospital or clinic. All programs include extended clinic hours, telephone triage, a case management system to follow up on ER visits, patient education, and access to behavioral health and dental services. The pilot projects have been operating since February 2009; examples of their intervention activities include

- taking advantage of DSHS Patient Review and Coordination Data, and receiving monthly information on clinic patients who are frequent users of ER services
- creating a "golden ticket" for nonemergent ER patients to use at an urgent care setting
- using a full-time ER patient liaison to redirect nonemergent patients to the clinic during normal business hours
- partnering with a local fast-food franchise to create tray tables that provide health education to parents about emergent and nonemergent health care³⁵

As of the publication of this HEDIS report, MPA was analyzing the results of the ER pilots and was preparing a report with recommendations to be submitted to CMS.

Recent state legislation (HB 2956) requires DSHS and a coalition of health plans, physicians, and hospitals to design a system of hospital quality incentive payments, aimed at improving outcomes for hospital patients. These payments, administered by MPA, are to take effect July 1, 2012. MPA is developing improvement measures that include reducing preventable ER visits by Medicaid managed care enrollees. Eligible hospitals are to submit documentation to MPA by September 2011 describing their strategic plans for preventing ER visits, including community partnerships, data reporting, follow-up with ER patients, and continuing education for hospital team members.

Discussion and recommendations

Research suggests that health plans can reduce ER visits and costs by informing providers about their members who use ER services and by educating enrollees about appropriate ER use.

Acumentra Health recommends that MPA

- consider organizing a collaborative PIP among MCOs to reduce nonurgent ER utilization, providing an opportunity to test multiple interventions across plans
- encourage MCOs to provide routine ER utilization reports to providers
- promote enrollee education to help reduce preventable ER visits

Race/Ethnicity Diversity of Health Plan Membership

Disparities exist among racial and ethnic groups in terms of the incidence of disease, access to health care, receipt of services, and health outcomes. A 2002 study by the Institute of Medicine (IOM) found that members of racial and ethnic minorities receive lower-quality health care than white people, even when insurance status, income, age, and severity of conditions are comparable.³⁶ In response to these findings, the IOM created a chartbook that can help policy makers, researchers, practitioners, and teachers begin to understand disparities in their communities and to formulate solutions.³⁷

This is the third year that MPA has required the Healthy Options plans to report this HEDIS measure as a method to identify characteristics of the Medicaid enrollees served by the plans. The measure reports an unduplicated count and percentage of members enrolled at any time during the measurement year, by race and ethnicity. Historically, some MCOs experienced difficulty in identifying race and ethnicity for members. Beginning in 2010, if an MCO cannot report this measure, MPA will assign a corrective action to the plan.

Tables 61–67 in Appendix B present complete demographic data for each health plan. The data should be interpreted with caution because of the wide variation among plans in the consistency of the data reported, evident from Tables 4–6 below.

Table 4. Unduplicated membership and known race and ethnicity by health plan, reporting year 2010.

	ANH	CHP	CUP	GHC	KPNW	MHW	RBS	State
Unduplicated membership	3,120	265,879	53,543	30,227	880	405,470	49,402	808,519
% with known race	83.9	63.6	80.8	86.2	1.3	62.8	62.2	65.1
% with known ethnicity	1.4	100.0	0.0	1.8	1.0	66.8	24.9	68.0

Table 5. Ethnicity of enrollees by health plan, reporting year 2010.

	Hispanic		Not Hispanic		Unknown		Totals	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
ANH	44	1.41	0	0.00	3,076	98.59	3,120	100.00
CHP	53,411	20.09	212,466	79.91	0	0.00	265,877	100.00
CUP	0	0.00	0	0.00	53,543	100.00	53,543	100.00
GHC	545	1.80	0	0.00	29,682	98.20	30,227	100.00
KPNW	0	0.00	9	1.02	871	98.99	880	100.00
MHW	38,405	9.47	232,287	57.29	134,778	33.24	405,470	100.00
RBS	12,292	24.88	0	0.00	37,110	75.12	49,402	100.00
State total	104,697	12.95	444,762	55.01	259,060	32.04	808,519	100.00

The 2010 statewide percentages for both racial and ethnicity data are in line with the 2009 numbers. All plans except KPNW provided racial data for at least 62 percent of their enrollees. CHP reported ethnicity data for all enrollees, and MHW reported ethnicity data for two-thirds; these two plans account for more than 80 percent of Healthy Options enrollees. Large gaps remain in ethnicity reporting by other plans.

Table 6. Race of enrollees by health plan, reporting year 2010.

Race	ANH n (%)	CHP n (%)	CUP n (%)	GHC n (%)	KPNW n (%)	MHW n (%)	RBS n (%)	State n (%)
White	2,333 (74.78)	102,149 (38.42)	34,358 (64.17)	18,263 (60.42)	7 (0.8)	201,526 (49.7)	21,635 (43.79)	380,271 (47.03)
African American	62 (1.99)	14,066 (5.29)	1,669 (3.12)	3,153 (10.43)	0 (0)	30,761 (7.59)	1,222 (2.47)	50,933 (6.30)
American Indian	26 (0.83)	1,663 (0.63)	178 (0.33)	415 (1.37)	0 (0)	2,856 (0.7)	477 (0.97)	5,615 (0.70)
Asian	45 (1.44)	8,762 (3.3)	783 (1.46)	1,335 (4.42)	1 (0.11)	18,673 (4.61)	588 (1.19)	30,187 (3.73)
Native Hawaiian	0 (0)	4,485 (1.69)	239 (0.45)	797 (2.64)	0 (0)	949 (0.23)	0 (0)	6,470 (0.80)
Some other race	151 (4.84)	37,617 (14.15)	6,024 (11.25)	2,080 (6.88)	3 (0.34)	0 (0)	6,808 (13.78)	52,683 (6.52)
Two or more races	0 (0)	238 (0.09)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	238 (0.03)
Unknown	503 (16.12)	96,897 (36.44)	10,292 (19.22)	4,184 (13.84)	869 (98.75)	150,705 (37.17)	18,672 (37.8)	282,122 (34.90)
Plan total	3,120 (100)	265,877 (100)	53,543 (100)	30,227 (100)	880 (100)	405,470 (100)	49,402 (100)	808,519 (100)

Discussion and recommendations

Accurate data on race and ethnicity can help healthcare system managers determine the drivers of disparate care, identify opportunities for system improvements, and use resources more efficiently. Patients can benefit from recognition and validation of their different identities and needs, leading to greater patient satisfaction and engagement in treatment, which, in turn, can lead to improved outcomes.

Although most MCOs were able to report race and ethnicity data for their populations in 2010, more than one-third of all enrollees' race and/or ethnicity were categorized as "unknown."

According to the Health Research and Educational Trust (HRET), valid and reliable data on patient race and ethnicity are "fundamental building blocks for identifying differences in care and developing targeted interventions to improve the quality of care delivered to specific populations." Such data also may help health plans prevent discrimination on the basis of race and national origin.³⁸ The IOM's Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement has recommended collection of more granular data on ethnicity and language needs in addition to race and Hispanic ethnicity categories.³⁹

The HRET website cited above suggests best practices in collecting and reporting data on race, ethnicity, and primary language. The organization's Disparities Toolkit offers a uniform framework for obtaining these data directly from enrollees or their caregivers in an efficient, effective, and respectful manner. Acumentra Health joins HRET in recommending these practices for MCOs seeking to standardize data collection:

- Information should always be provided by patients or their caretakers, never by observation alone.
- For health plans, data collection should take place at enrollment.
- Use U.S. Census or Office of Management and Budget racial and ethnic categories for reporting purposes.
- Store the data in a standard electronic format for easy linking to clinical data.
- Address patient concerns up front and clearly before obtaining information.
- Provide ongoing training and evaluation for health plan staff.

Washington Medicaid Integration Partnership (WMIP)

The WMIP seeks to integrate medical, mental health, substance abuse, and long-term care services for categorically needy aged, blind, and disabled Medicaid beneficiaries. These beneficiaries, who tend to have complex health conditions, are the fastest growing and most expensive segment of DSHS's client base. Nationwide, dual-eligible enrollees represent 18 percent of Medicaid enrollees and 16 percent of Medicare enrollees, yet they account for 46 percent of total Medicaid and 25 percent of total Medicare expenditures. Total federal and state costs for health care for dual eligibles are estimated at \$250 billion per year.⁴⁰

Intermediate goals of the WMIP include improving the use of mental health and substance abuse services, which account for a large portion of total healthcare costs.⁴¹ Longer-term objectives are to improve the patients' quality of life and independence, reduce ER visits, and reduce overall healthcare costs.

The state contracts with MHW to conduct the WMIP in Snohomish County. MHW is expected to

- provide intensive care coordination to help clients navigate the healthcare system
- involve clients in care planning
- assign each client to a care coordination team and have consulting nurses available on the phone 24 hours per day
- use the Chronic Care Model to link medical, pharmacy, and community services
- use standards for preventive health and evidence-based treatment to guide care plan development and improve health outcomes

The WMIP target population is Medicaid enrollees age 21 or older who are aged, blind, or disabled, including Medicaid-only enrollees and those dually eligible for Medicare and Medicaid. WMIP excludes children under 21, Healthy Options enrollees, and recipients of Temporary Assistance for Needy Families. As of October 2010, about 3,800 individuals were enrolled in WMIP.

For 2010, MHW reported seven HEDIS measures for the WMIP population: comprehensive diabetes care, inpatient care utilization—general hospital/acute care and nonacute care, ambulatory care utilization, anti-depression medication management, follow-up after hospitalization for mental illness, and use of high-risk medications for the elderly. MHW also calculated four non-HEDIS measures for the WMIP: chronic dementia, falls, depression, and transition of care. The results of those four measures are not analyzed in this report.

In addition, MHW calculated four “HEDIS-like” measures for the WMIP program: chronic dementia, falls, depression, and transition of care. Data collection and calculation were performed according to the specifications as they were written. However, modifications and clarifications to the denominator were made over the reporting cycles. As a result of the modifications, quarterly rates were not eligible for comparison.

Because the WMIP population differs categorically from the Healthy Options population, it is not feasible to compare the WMIP data meaningfully with the data reported by Healthy Options plans or with national data for health plans serving traditional Medicaid recipients.

Comprehensive diabetes care

Figure 29 presents the WMIP results for comprehensive diabetes care in reporting years 2007–2010. For a discussion of these measures and their definitions, see page 26.

Except for HbA1c testing and HbA1c poor control, the 2010 rates were lower than the rates reported in 2009, though not significantly so. (Note: the higher rate for HbA1c poor control represents a worse result.) However, the four-year increase in nephropathy monitoring, from 55.91 percent in 2006 to 81.58 percent in 2010, is statistically significant.

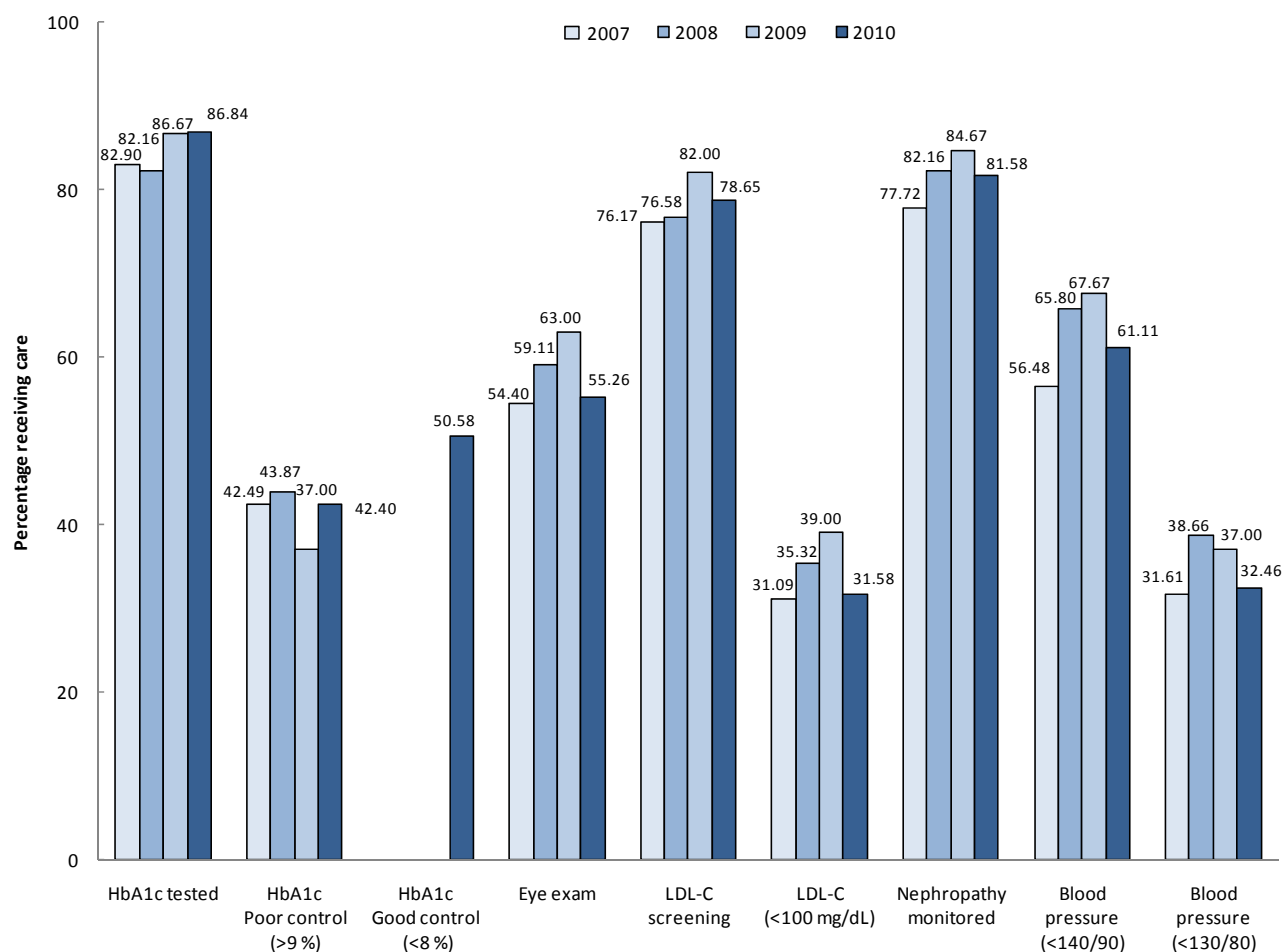


Figure 29. WMIP comprehensive diabetes care measures, reporting years 2007–2010.

Utilization measures

Figures 30–34 present the results of WMIP utilization measures for the past four years:

- inpatient utilization discharges, days, and average length of stay—total inpatient (acute), medical, surgical, and inpatient (nonacute)
- ambulatory care visits (outpatient, ER, surgery or procedure, observation room)

The inpatient nonacute care measure summarizes usage of nonacute care in hospice, nursing home, rehabilitation, skilled nursing facility, transitional care, and respite settings, except for services with a principal diagnosis of mental health and chemical dependency.

In 2010, discharges decreased for total inpatient acute care, medicine, and nonacute inpatient care; however, the changes were not statistically significant. Surgical discharges increased from 2009, but again, the change was not statistically significant (Figure 30).

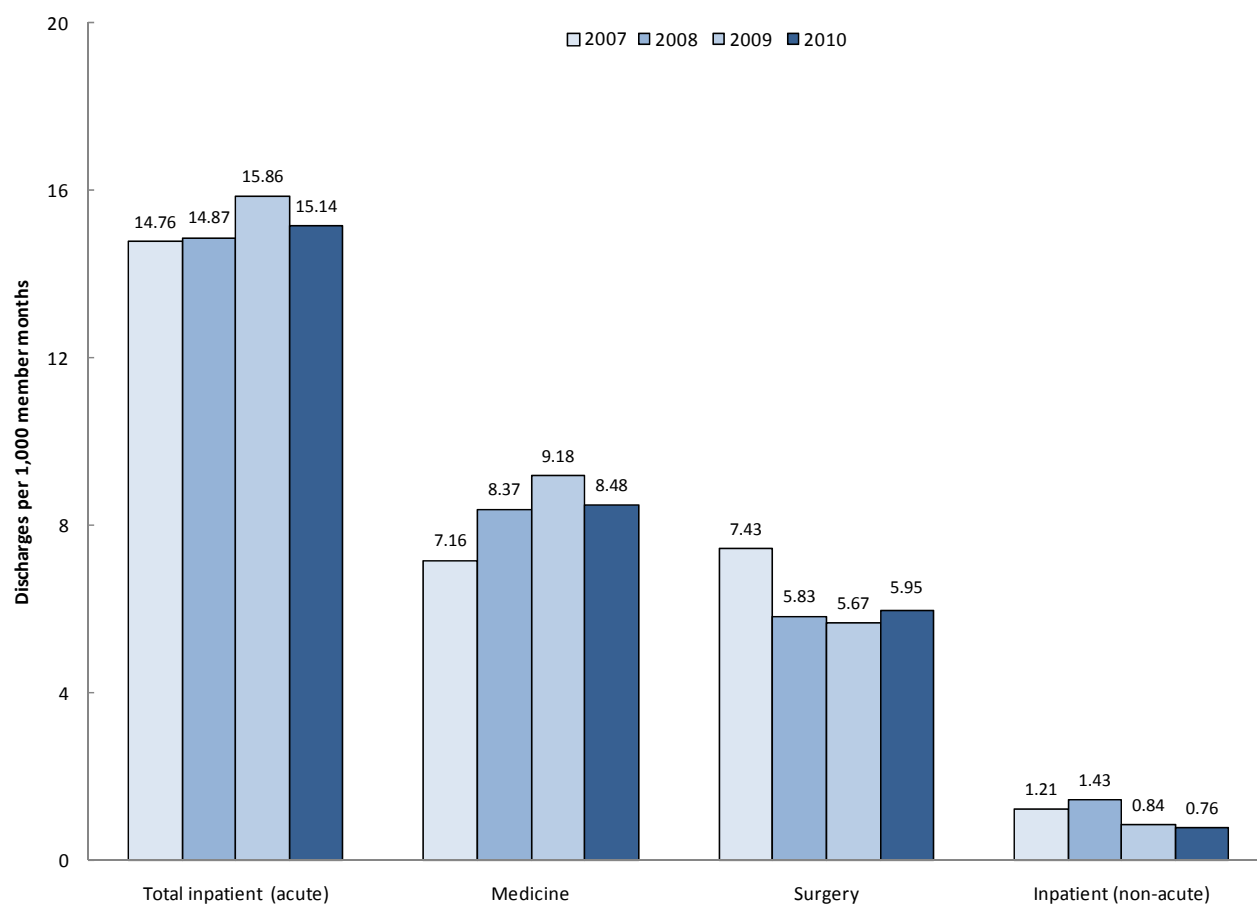


Figure 30. WMIP inpatient utilization discharges, reporting years 2007–2010.

Inpatient acute, surgical, and nonacute days for WMIP enrollees decreased from 2009 to 2010, but the changes were not statistically significant (Figure 31).

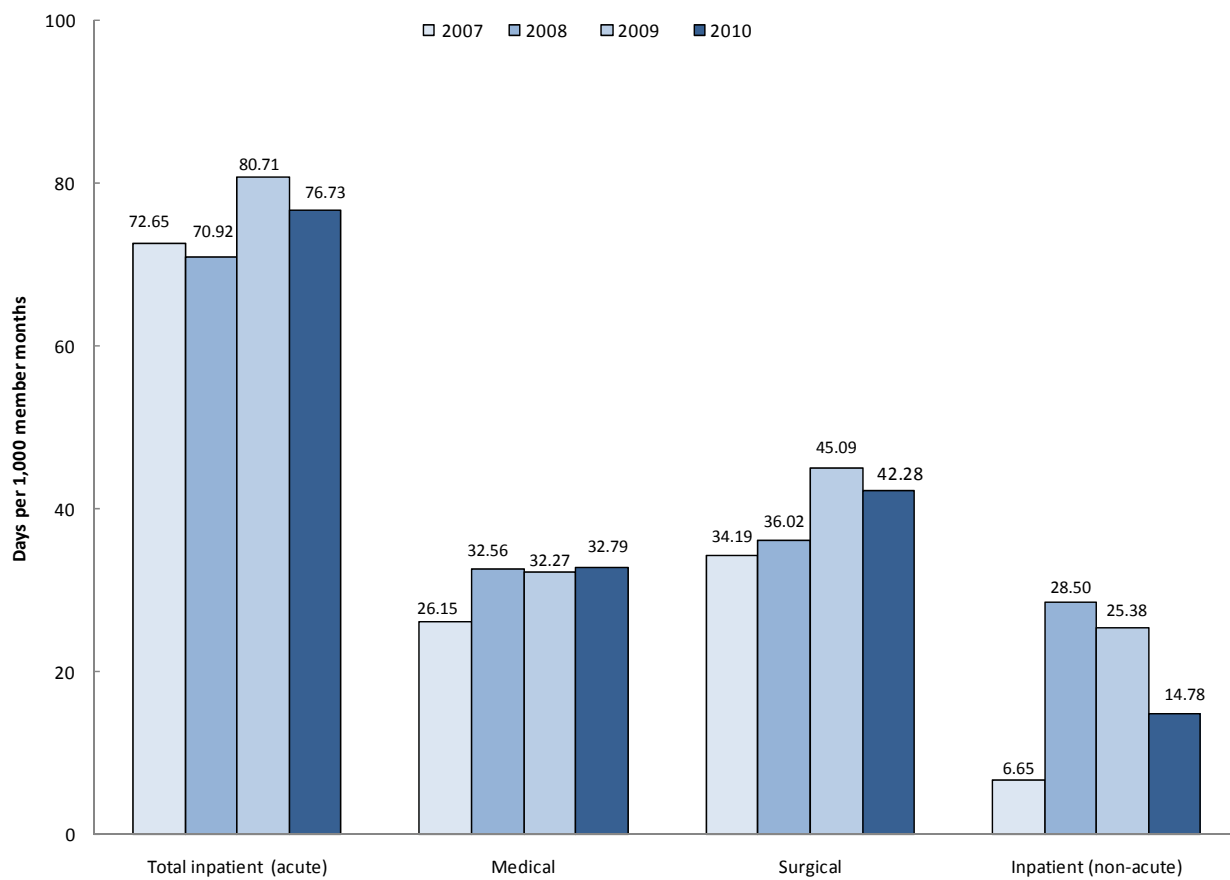


Figure 31. WMIP inpatient utilization days, reporting years 2007–2010.

The average length of stay (ALOS) for WMIP enrollees in surgical and nonacute care decreased, but not significantly (Figure 32). Medical ALOS increased, but not significantly.

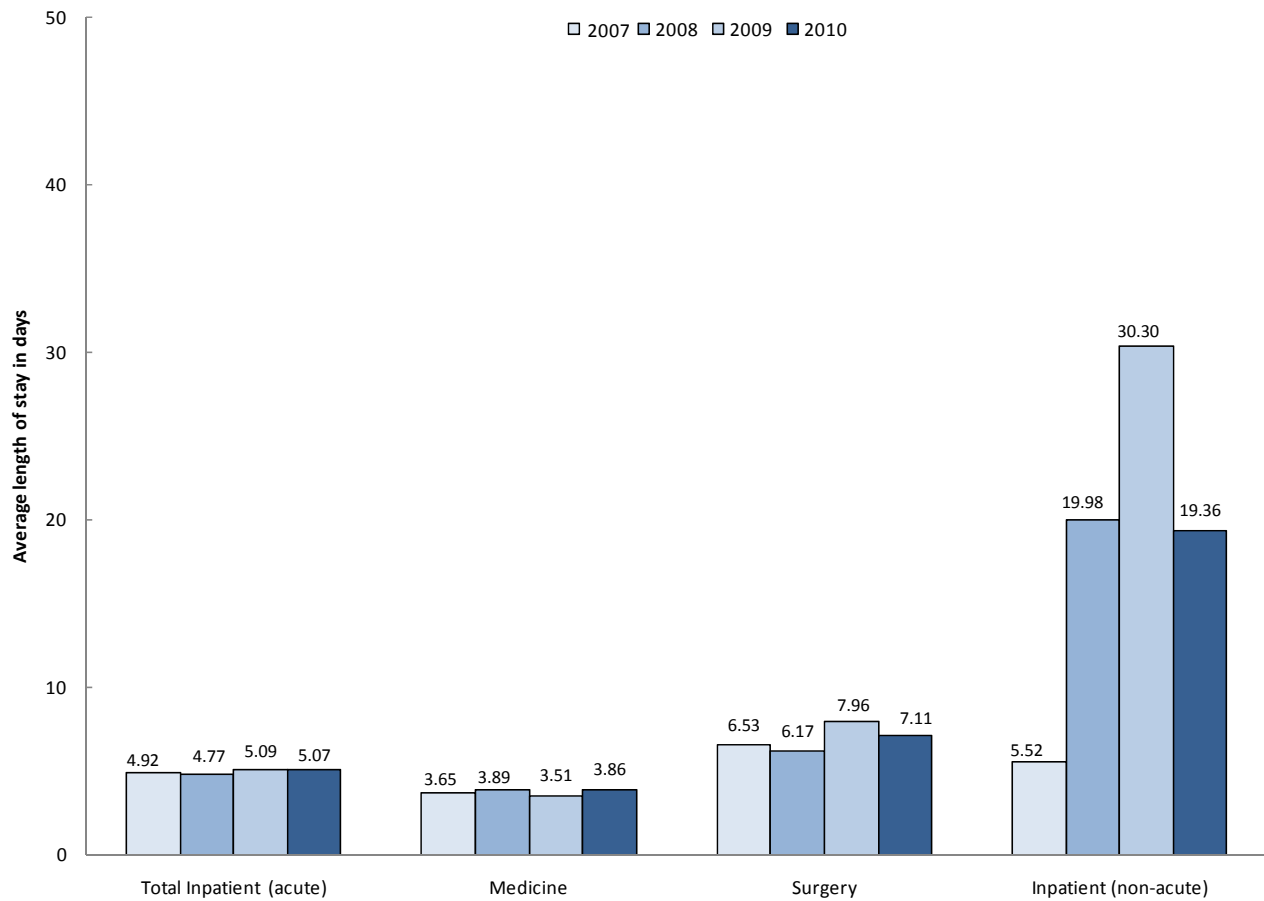


Figure 32. WMIP inpatient utilization average length of stay, reporting years 2007–2010.

Looking at the ambulatory care measures, outpatient visit rates for WMIP enrollees increased significantly in 2010, while ER visit rates remained flat (Figure 33).

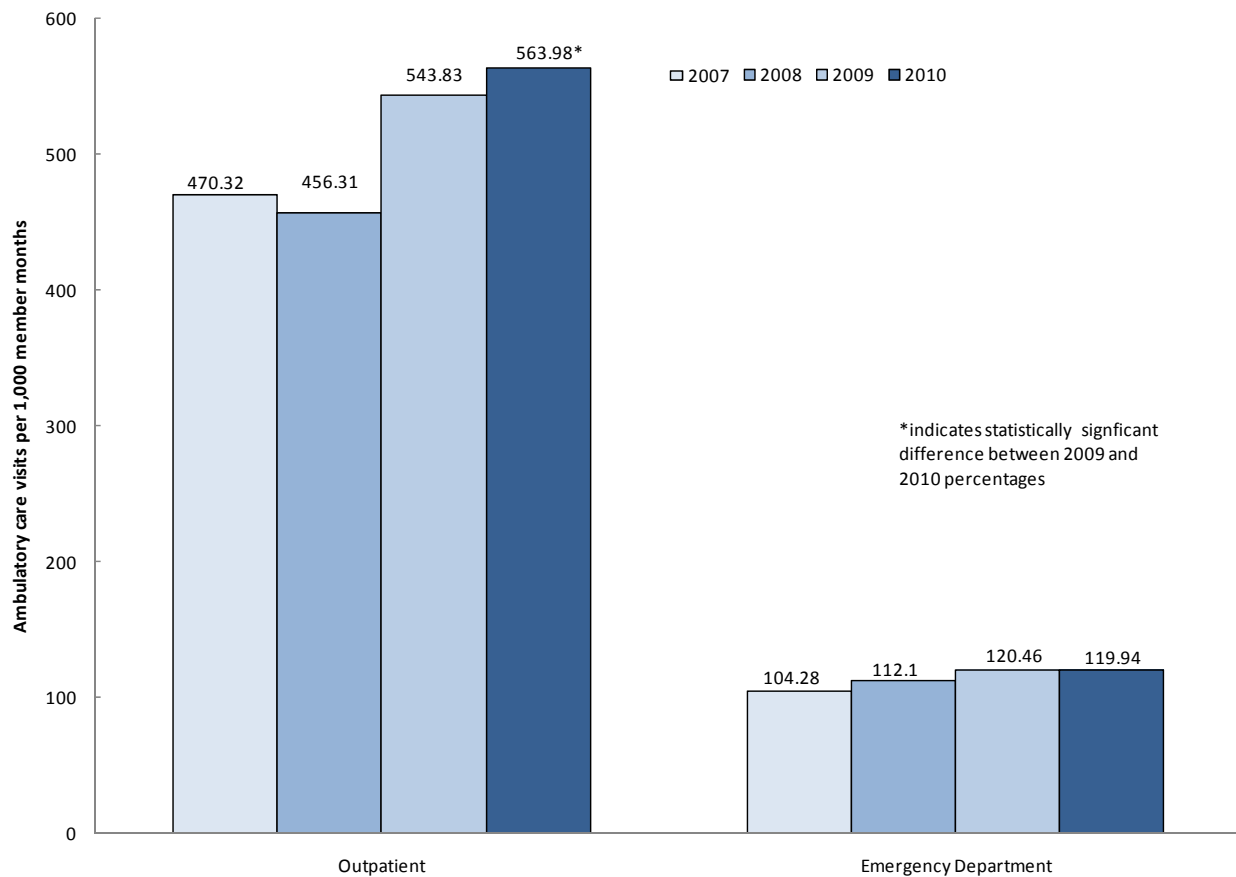


Figure 33. WMIP ambulatory care visits, outpatient and emergency department, reporting years 2007–2010.

The rate of ambulatory care visits for surgery or procedures increased in 2010, but the change was not significant (Figure 34).

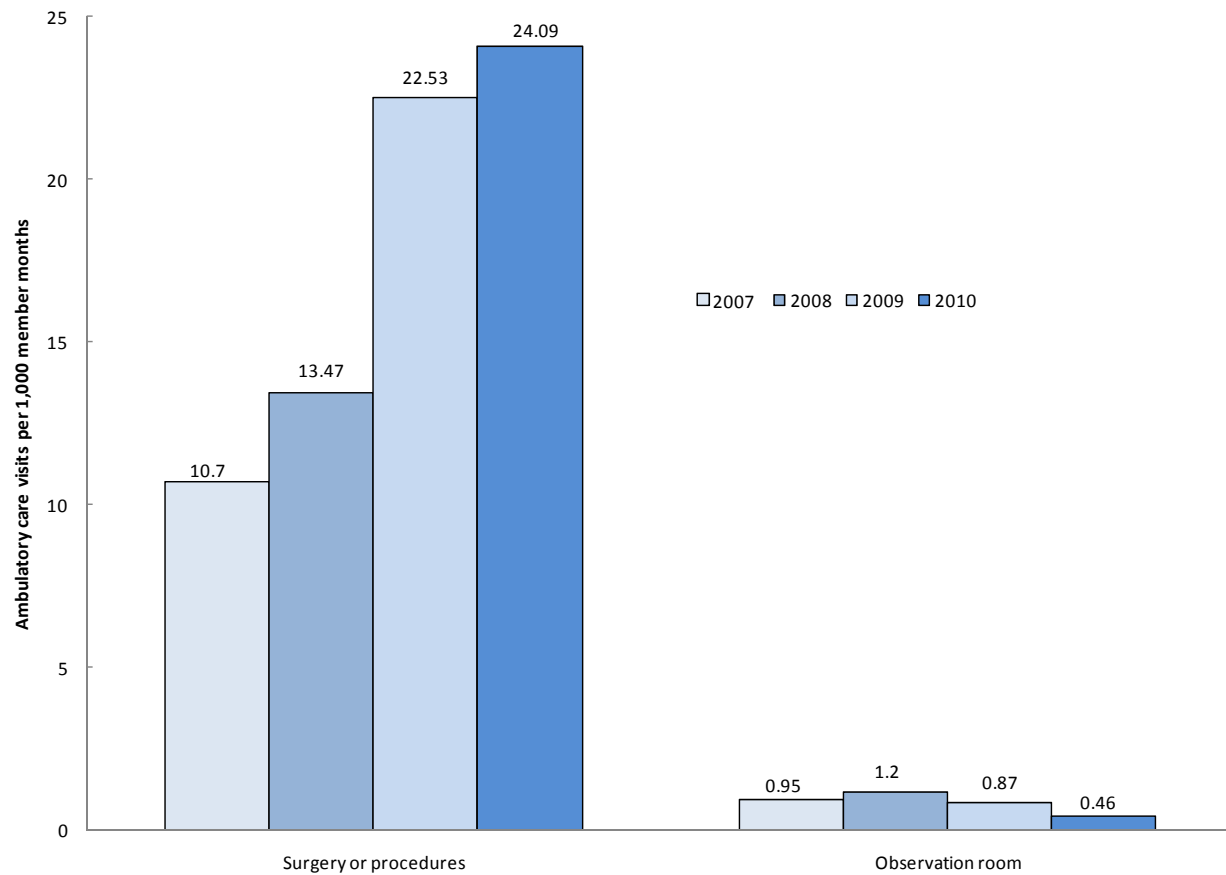


Figure 34. WMIP ambulatory care visits, surgery or procedures and observation room, reporting years 2007–2010.

Additional measures

Figures 35 and 36 present WMIP results for two behavioral health measures from 2008 through 2010.

The antidepressant medication management measure examines

- the percentage of newly diagnosed and treated patients who remained on an antidepressant medication for the treatment of major depression for at least 12 weeks (effective acute phase treatment)
- the percentage of newly diagnosed and treated patients who remained on an antidepressant medication for the treatment of major depression for at least six months (effective continuation phase treatment)

The percentage of WMIP enrollees receiving effective acute phase treatment essentially held steady in 2010. The percentage receiving effective continuation phase treatment increased slightly, but the change was not significant (Figure 35).

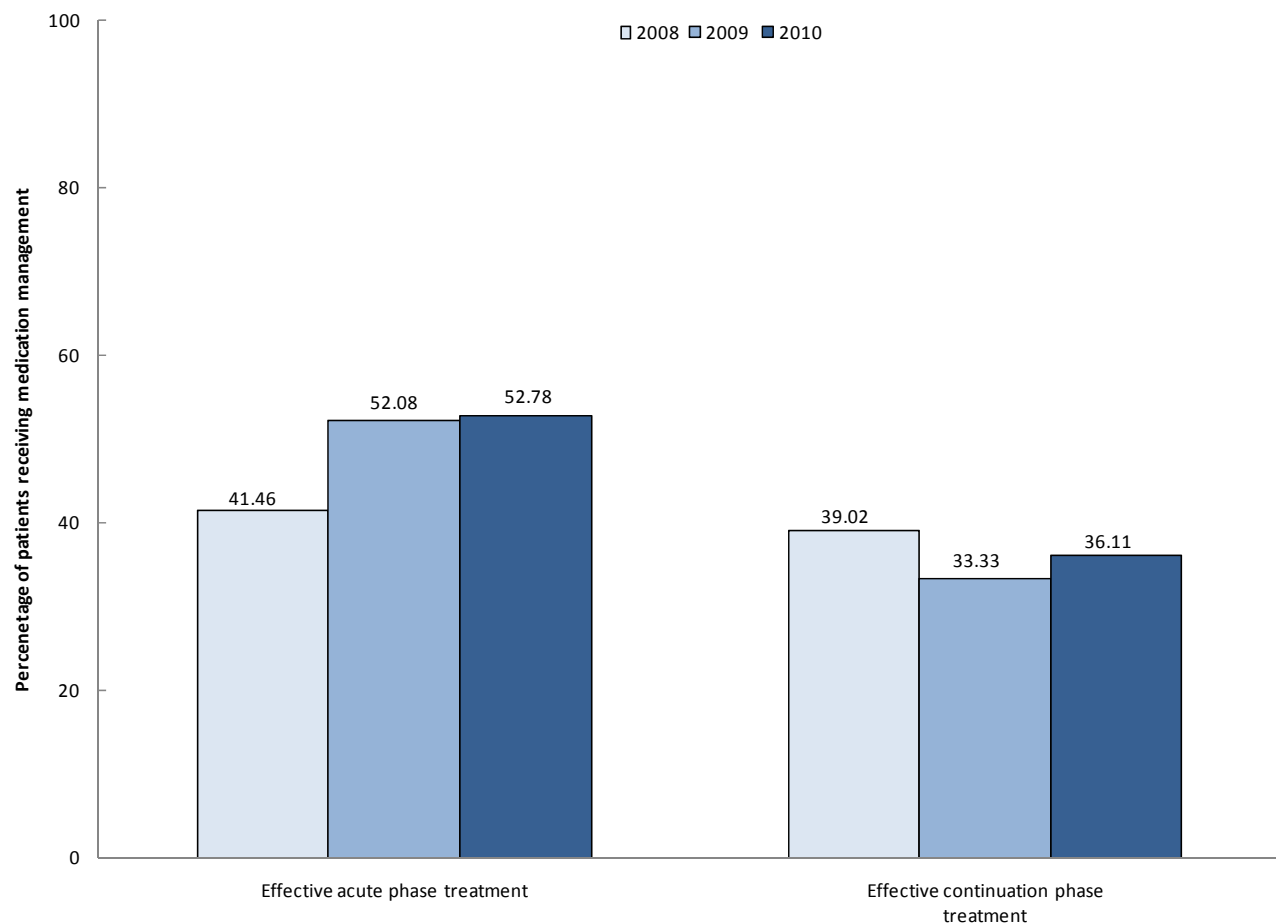


Figure 35. WMIP antidepressant medication management, reporting years 2008–2010.

The measure of follow-up after hospitalization for mental illness looks at continuity of care—the percentage of enrollees age 65 or older who were hospitalized for selected mental disorders and who were seen on an outpatient mental health provider within 30 days or within 7 days after their discharge from the hospital. As shown in Figure 36, the percentages of WMIP enrollees receiving timely follow-up care decreased in 2010; the decline in the 30-day follow-up rate was statistically significant.

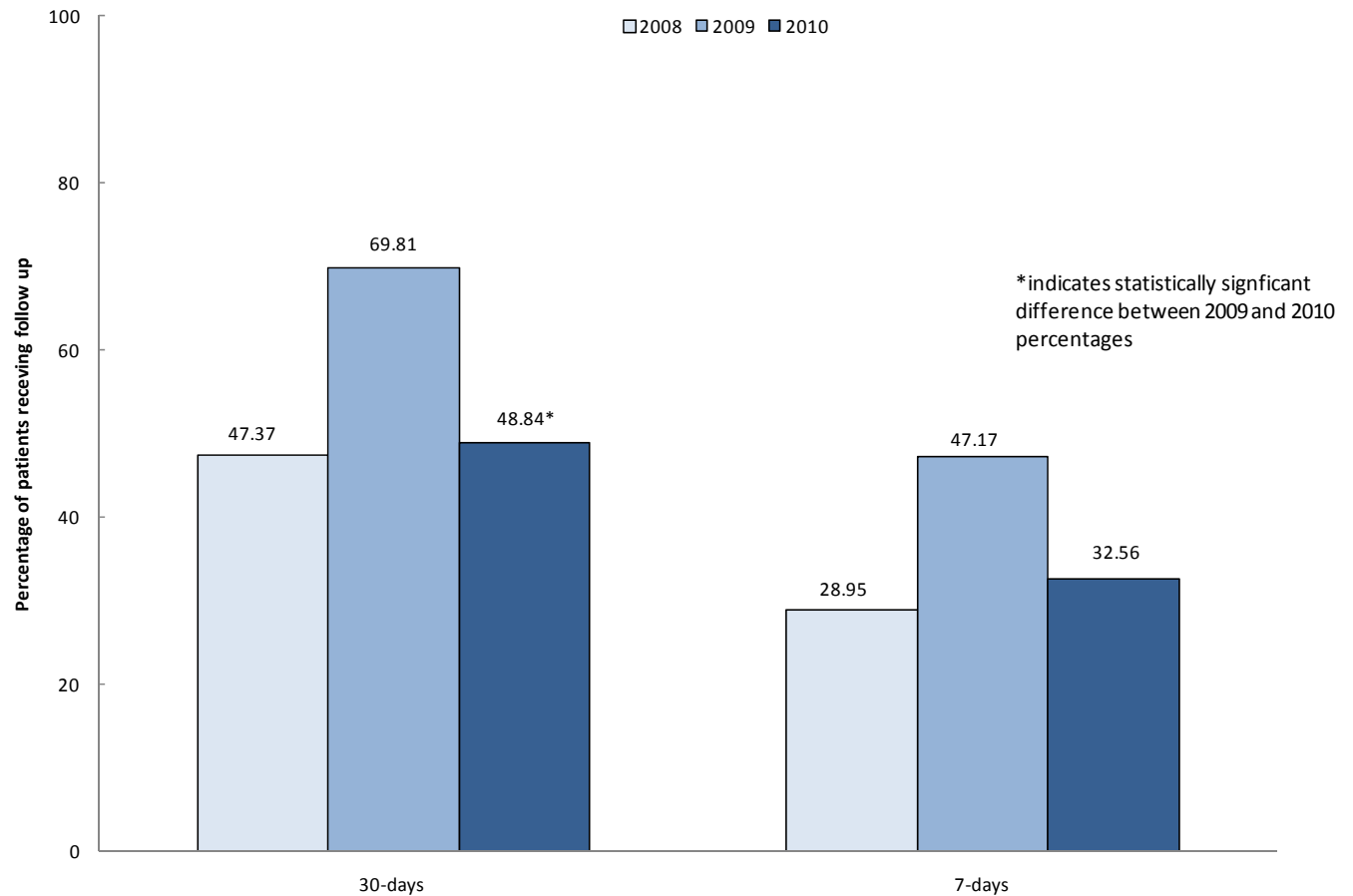


Figure 36. WMIP follow-up after hospitalization for mental illness, reporting years 2008–2010.

Figure 37 shows four years of data on the use of high-risk medications in the aged—the percentage of enrollees age 65 or older who received at least one prescription, or at least two different prescriptions. Categories of high-risk medications include skeletal muscle relaxants, calcium channel blockers, and antihistamines. For this measure, NCQA states that a lower rate represents better performance. The percentages for both indicators have dropped slightly each year since 2007, pointing to better management of these medications for WMIP enrollees.

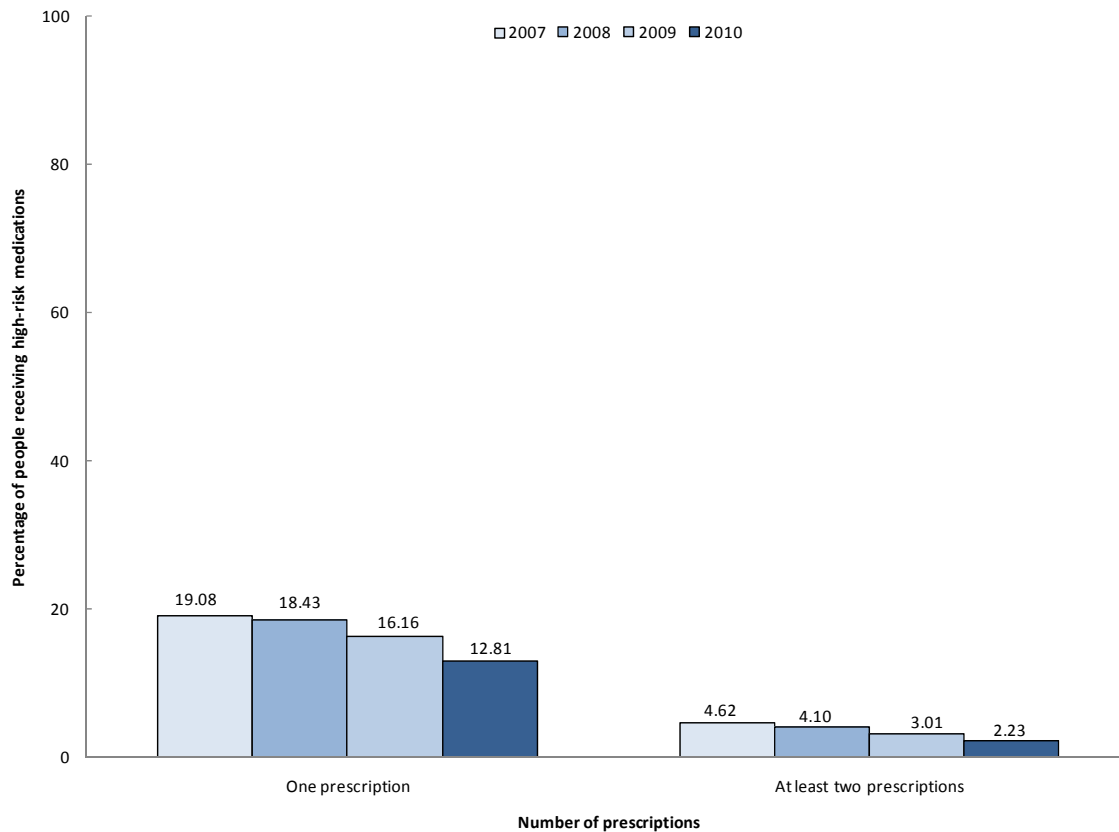


Figure 37. WMIP use of high-risk medications in the aged, reporting years 2007–2010.

Discussion and recommendations

The WMIP program serves enrollees who exhibit complex healthcare issues, including enrollees who receive mental health services and who are in long-term care. According to DSHS, these enrollees typically have received substantial amounts of inappropriate care in hospitals and ER facilities due to lack of care management by physicians and nursing facilities and because the clients were unaware of how to obtain access to the care available to them.

Performance measure results to date indicate steady progress in management of antidepressant medications and high-risk medications in the aged. With respect to diabetes care, however, the screening and utilization measures show mixed results, indicating that this complex population requires a high level of coordination to ensure that clinical guidelines are met.

Current research regarding the dual-eligible population focuses on reducing hospitalizations and improving outcomes for beneficiaries with multiple chronic illnesses who are not cognitively impaired. Three types of interventions have been demonstrated to be effective:

- **Transitional care interventions** engage patients while they are hospitalized and follow them intensively for four to six weeks after discharge to ensure that patients understand and can adhere to post-discharge instructions for medication and self-care, recognize symptoms that signify potential complications requiring immediate attention, and make and keep follow-up appointments with their PCPs. These interventions use advanced practice nurses and “transition coaches.” In successful interventions, these professionals had substantial amounts of in-person contact with their patients.
- **Self-management education interventions** engage patients from four to seven weeks in community-based programs (using medical and nonmedical professionals) designed to “activate” them in managing their chronic conditions. Patients learn to self-manage symptoms, participate in activities that maintain function and reduce health declines (e.g., taking their medications properly), participate in diagnostic and treatment choices, and collaborate with their providers.
- **Coordinated care interventions** identify patients with chronic conditions that are at substantial risk of hospitalization in the next 12 months; conduct initial assessments and care planning; and monitor patients’ symptoms and self-care on an ongoing basis. Registered nurses often coordinate this care. However, for some patients, social workers assist with assessing eligibility and arranging services such as transportation, home-delivered meals, emergency response systems, advanced care planning, and coordination with home health agencies. Information is coordinated among the patient, PCP, and caregivers.^{42,43}

The authors suggest that the “optimal” care coordination model includes

- augmenting effective ongoing care coordination with transitional care
- offering group education on self-management, while tailoring educational materials to people with lower educational levels and assessing their comprehension
- establishing high-quality programs using the above-mentioned interventions

Acumentra Health offers this additional recommendation:

- Conduct member-level analysis to “drill down” on performance measures and target specific areas of improvement.

In May 2009, the Center for Health Care Strategies (CHCS) launched an initiative called Transforming Care for Dual Eligibles. Seven states will implement strategies to improve care and control costs for dual-eligible enrollees. Colorado, Maryland, Massachusetts, Michigan, Pennsylvania, Texas, and Vermont will receive in-depth technical assistance addressing program design, care models, contracting strategies, and financing mechanisms.⁴⁴ The findings, when they become available, are likely to prove useful for WMIP program managers.

In March 2010, CHCS produced a Technical Assistance Tool entitled, “Options for Integrating Care for Dual Eligible Beneficiaries.”⁴⁵ Integration options are grouped into four broad categories: Special Needs Plans, Program for All-Inclusive Care for the Elderly, Shared Savings Models, and States as Integrated Care Entities. The toolkit further discusses the elements necessary for implementing integrated care including:

- strong patient-centered care based in accountable primary care homes
- comprehensive, multi-disciplinary care teams that coordinate and provide the full range of medical, behavioral, and long-term support services and needs
- robust data sharing and information systems to promote care coordination
- enhanced use of home- and community-based long-term care services
- financial alignment that impels integration of care
- strong consumer protections that ensure access to longstanding providers and involve consumers in program design

Other integration program information can be found on CHCS’s website, www.chcs.org.

Conclusions

The Healthy Options plans have reported positive six-year trends in many HEDIS measures, reflecting long-term improvements in providing care for enrollees. In 2010, for 17 of the 23 measures or indicators (excluding utilization measures) for which comparisons are possible, the statewide average was higher than in 2009, and 3 of the increases were statistically significant. Of the 6 indicators for which the average fell, 1 fell significantly from 2009.

Utilization measures show a positive pattern. The Healthy Options average is in line with or below the NCQA average for all indicators or measures except for maternity discharges.

The six-year improvement has been significant for childhood immunizations and for WCC visits for infants and children. CHP deserves to be commended for offering performance incentives to its clinics. CHP supports two reward programs: one rewards enrollees for obtaining the health care they need, and the other rewards clinic staff for identifying children who are not up-to-date for immunizations and WCC. Best practices such as these have been shown to improve care significantly for young people.

The relationship between participation in collaboratives and improved performance has been well documented.^{46,47,48} The Healthy Options plans, through their participation in collaboratives and other learning events in Washington, are learning to apply best practices in patient care.

The Healthy Options plans would benefit from improving the accuracy and completeness of their encounter data. Plans that use mostly administrative data collection for measures with the hybrid option can save costs in data reporting. Standard rates for conducting a chart review may range from \$30 to \$50 per chart. Plans incur additional costs when a reviewer visits more than one provider's office in an attempt to verify documentation. However, our analysis suggests that heavy reliance on administrative data may result in generation of less than optimal HEDIS rates unless the reported encounters completely capture all services provided. However, as discussed previously, other states have begun to explore the option of administrative-only reporting.

MPA required the Healthy Options plans to submit de-identified member-level data (including elements for gender, primary language, race/ethnicity, and county) on childhood immunizations for 2009 and 2010, and on WCC visits for 2010. Continuing reporting of these elements should enable the state and the health plans to analyze details of their populations, providing insight into appropriate targets for QI activities.

Recommendations

Health plans may improve care for their Medicaid enrollees by participating in joint projects or pooling resources to target areas such as childhood immunizations and WCC. Acumentra Health continues to recommend that MPA consider organizing a statewide PIP or collaborative project that would pool health plan resources and capitalize on partnerships to improve WCC visit rates.

The six-year trends in HEDIS rates bear out the incremental nature of change. Ideally, the reported measures should not be considered in isolation to define plan performance; rather, the outcomes present an opportunity for plans to examine additional data sources to determine whether a “drill-down” analysis or targeted QI project may be appropriate. As rates fluctuate from year to year, MPA and the plans need to design sustainable changes to support continuing improvement. Acumentra Health recommends that the Healthy Options plans

- conduct validation studies to improve the quality of encounter data
- conduct member-level analysis to “drill down” on core preventive measures to identify gaps in care
- provide HEDIS-specific performance feedback to clinics and providers on a frequent and regular schedule
- monitor their HEDIS rates at least quarterly, using administrative data
- implement interventions to improve services to underserved groups, such as Russian-speaking populations
- support and reward providers who develop medical homes for their patients and who improve their quality indicators
- consider eliminating the requirement for hybrid data collection for well-child care
- consider organizing a collaborative PIP among MCOs to reduce nonurgent ER utilization, encourage MCOs to provide routine ER utilization reports to providers, and promote enrollee education to help reduce preventable ER visits

Finally, Acumentra Health recommends that MPA continue to help health plans study and overcome the barriers to collecting administrative data for HEDIS measures. For example, many national laboratories provide lab values through administrative methods, thereby reducing the reliance on medical charts. Identifying alternative methods of obtaining data would enable the plans to redirect some of the resources they spend on data collection toward providing better care for Healthy Options enrollees.

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